

**Life after Traumatic Injury:
Narratives of Embodiment and Identity
of United Kingdom ex-Service Personnel**

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PhD Sociology

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Declaration

Whilst registered as a candidate for the above degree, I have not been registered for any other research award. The results and conclusions embodied in this thesis are the work of the named candidate and have not been submitted for any other academic award.

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Abstract

This PhD thesis explores the life stories of veterans who were medically discharged due to severe trauma. Building upon Arthur Frank's (1995) 'illness narratives', the research aims to fill the gap about the individual, lived experiences of wounded service personnel in the United Kingdom Armed Forces. Through narrative inquiry with 12 participants (all male), this thesis covers a lengthy temporal dimension: from the point of injury to rehabilitation and beyond—to the hopes and fears that participants voiced for their futures. The thesis explores how poly-traumatic wounds and subsequent discharge impacts the life stories of injured service personnel through a multi-disciplinary lens inclusive of sociology, critical military studies, critical disability studies, psychology, and bio-medical studies. Investigating rehabilitation and medical discharge, participants clarify how continuity and change affects their transition into civilian society. It also highlights a 'post-military' versus 'ex-military' identity for participants, as the narratives reflect still being connected to their Armed Forces career. Participants' careers range from 6 to 26 years, serving in the Royal Air Force, Royal Marines, and the British Army. The analysis of the collected narratives within this research illuminates how service members who acquire a disability whilst in service adapt, how they find various forms of agency post-discharge, and their negotiation of physical autonomy in their daily lives. I suggest three new narrative typologies from my research data—'anchored', 'adapted', and 'ascending'—to categorise participants' levels of physical independence. Two new concepts are also introduced: 'conditional corporeality' and 'body rationing'. Lastly, I conclude the thesis with key findings and areas for future research.

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Dedication

This work is dedicated to my true loves: Blake, Genevieve, and Evan, who are my bright stars in the night sky.

Dissemination

In accordance with the university submission procedure, the following lists where this research and its aims were presented:

Formal presentations:

- British Association of Prosthetists and Orthotists, Coventry, UK, March 2017
- University of Portsmouth Humanities and Social Sciences Conference, Portsmouth, UK, October 2017
- Veterans and Families Institute, Chelmsford, UK, October 2017
- European International Studies Association Conference; Pan-European Conference on International Relations, Prague, Czech Republic, September 2018

Informal presentations:

- Defence Medical Rehabilitation Centre, Headley Court, Surrey, UK, March 2016
- Portsmouth Enablement Centre, Portsmouth, UK, October 2016
- University College London, London, UK, June 2017
- HMS Drake, HMNB Devonport, Plymouth, UK, July 2017
- Commando Training Centre Royal Marines, Lympstone, Exmouth, UK, October 2017
- Defence Research Network Collaboration Workshop, Anglia Ruskin University, Chelmsford, UK, February 2018
- Military Human Course, York, UK, June 2018

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- University of Portsmouth Postgraduate Researcher Days, October 2016
- Forces in Mind Trust Research Centre Conference, London, UK, October 2018

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Chapter 1: Introduction

Context of Research

In the time period of 1 January 2000 to 31 March 2014, 23,682 service personnel were medically discharged from the British Armed Forces (Ministry of Defence: Defence Statistics (Health), 2014). Almost sixty percent of that number were due to ‘Musculoskeletal disorders and Injuries’ (ibid.), which can be viewed as a significant loss to the Forces and also a significant cost to the healthcare system. However, numbers and statistics do not explain what injury is, the impact it has on the person’s body, nor the effects to their life. Whilst one can find publicly available information about the services provided to injured service personnel by the Ministry of Defence¹, those documents do not always capture or reveal the story lived out each day by someone wounded in service to their country.²

There is an increased salience of wounded veteran bodies post-Iraq and Afghanistan, yet cultural stories or representations that accompany this are often simplistic, such as stories of heroisation (e.g., the Invictus Games’ participants), or problematic (e.g., posttraumatic stress disorder). This research sought to address the delimited ways in which veteran bodies and afterlives of conflict are understood in scholarship, by collecting and analysing qualitative data about the lived experiences of recently injured ex-service personnel. Further, a multidisciplinary

¹ These documents include, for example, the Armed Forces Covenant, the War Pension Scheme, the Armed Forces Compensation Scheme, Armed Forces Pensions, and Veterans Badge application: www.gov.uk/government/organisations/veterans-uk.

² Forces in Mind Trust (FiMT) offers some in-depth information on veterans’ needs: www.fim-trust.org/reports/.

approach, with the intersection of embodiment, trauma, ageing, identity, disability, masculinity, and agency, is used within this research.

The origins of this research come from aspect of my personal and professional life. Personally, I come from a long lineage of men who served in the US Armed Forces and know first-hand how trauma in warfare can impact bodies, minds, and relationships. It was also made evident to me that a sense of military identity can remain within the person for far longer than their length of service. Additionally, I have many military friends—both veterans and currently serving within the Armed Forces. Professionally, it was whilst pursuing my higher education that I became aware of the issues surrounding multiple deployments of US service members to Iraq and Afghanistan. This awareness, along with my personal experiences, prompted me to begin researching and writing about military-related issues and was employed to work on a military reintegration project. The more I researched, the more I realised voices were missing in the majority of reports, scholarship, and books I read. Those ‘missing voices’ were of the people impacted—or injured—during their time serving their country.

Organisation of the thesis

The thesis is organised into nine chapters, beginning with the current Introduction. Chapter two, covering the creation and destruction of a military body, introduces the literature covering the basic training process, how that impacts and changes the person through embodied practices, and experiences of warfare. It will then move on to an overview of transition theories, which discuss normative and non-normative transitions in a life course. These frameworks assist in understanding the changes the people can face throughout the duration of their lives. It also illuminates the types of perspectives that transitions can hold for service members. The discussion moves on to include the exploration of Michael Bury’s ideas of biographical disruption and the issues surrounding, and

following, such disruption. Finally, the chapter ends with addressing traumatic wounds—physical wounds as well as unseen, mental wounds.

Chapter three is a further review of literature investigating the transition from wounded service member to civilian. The chapter then incorporates the concepts of heteronormative masculinity, stigma, and the issue of dependency, which are significant, as all of the participants were men. This literature highlighted concepts that might appear throughout this research. Further, terms concerning the body are introduced, such as ‘normal’ (able-bodied), ‘othering’, and ‘passing’ as normal. Pain and its legitimacy are then explored, followed by how stoicism can be used when one acquires a disability. The chapter turns to the significance of support after being injured. Carers, and their importance, are also discussed. The chapter concludes with how technology and prosthetics impact veterans in positive and negative ways.

Chapter four is the presentation of the methodology of this research. Beginning with the research questions surrounding the aim of the research, the chapter then discusses the chosen method of narrative inquiry. Narrative inquiry was chosen due to its ability to provide rich, detailed experiences. Presenting the need for psycho-social understanding in narratives, it further highlights the issues of biographical disruption along with chronic illness. Next, the discussion focusses on illness narratives, meaning-making, and storytelling. Drawing upon Arthur Frank’s seminal research on persons with chronic illness diagnoses, the need to tell—and hear—stories is presented. It is this intersubjective experience, found in qualitative methods, that influences this current research. Next, I explain the research design for interviewing and the necessary criteria for participating. The chapter turns to the recruitment process, explaining the ‘cultural immersion’ approach during the fieldwork phase. This approach incorporated visits to military bases and charity organisations, which were granted and helped inform the research. Participant information is introduced, inclusive of when and where they were injured as well as the cause of injury. Data collection, storage, and analysis are then discussed, followed by the ethics process and risk assessment

procedures. Finally, the chapter concludes with the discussion of military research methods, which examine the need for engaging with subjective, lived experiences, and my reflections about my positionality as a researcher.

Chapter five is the first empirical chapter and presents the participants' injury experiences. The chapter begins with a short overview of how an explosion physically affects the body. Next, the participants narrate the moment they were injured, describing their memories of that instant in time, and what they recall immediately afterward. Injuries sustained in warfare are presented first, 'Battlefield injuries', followed by injuries incurred in the United Kingdom, 'Homefront injuries'. I follow these narrations with an introduction of the medical care pathway, from point of wounding to rehabilitation, that the participants experienced. One of the overarching themes found within this research—adapting to a changed corporeality—is examined. Participant narratives highlight other themes found about the rehabilitation process: the importance of military continuity, camaraderie, and changes in how one perceives their injury.

Chapter six further draws upon empirical data, concentrating on the discharge process and medical discharge narratives. A synopsis of discharge is described, followed by narratives about presentation to the medical board. Participants explain how shocking it can be to experience medical discharge due to the abrupt finality of it and the disruption discharge can cause within their lives. The chapter then turns to military exit narratives, which describes multiple types of transitions experienced: planned, shocking, or somewhere in between those two types (what I describe as 'betwixt and between'). A planned exit typically led to a fluid military-to-civilian transition. The participants who spoke about shocking transitions focussed on their former career being 'taken away' as well as the transition period being equated to grieving. 'Betwixt and between' transitions were described as the decision to 'hold on' or 'let go' to one's military past. For some, a military identity was always present within their narratives; however, others spoke of an in-between—they realise they are no longer a service member, but they do not feel that they are a

civilian, either. The chapter then focusses on the difficulties that participants raised surrounding the return to civilian transition, such as differences between military and civilian mindsets as well as the needed connection to military friends. Issues of understanding—or, in some cases, tolerating—the ‘civvy’ mindset are highlighted. The chapter concludes with the importance of finding agency after a medical discharge.

Chapter seven investigates embodiment narratives, specifically focussing on physical autonomy. The social construction of disability and its implications are discussed. This chapter introduces my new typologies of ‘anchored’, ‘adapted’, and ‘ascending’. I turn to participants’ narratives about their corporeal experiences, discuss the embodied effects of a traumatic injury as well as explaining the negotiation of daily life following that injury. Beginning with the rejection of disabled labelling, participants explain the various ways wherein they approach social settings. Whilst some display their bodily differences, others speak about the desire to not appear as a person with acquired disabilities. The chapter concludes with narratives of a reality of bodily limits and limitations, thus exposing two new concepts of ‘conditional corporeality’ and ‘body rationing’. These new concepts highlight the ways in which participants retain their physical independence.

The final empirical chapter, chapter eight, focusses on the narratives of making meaning of life, both now and for the future, with an emphasis on what post-injury, post-military life entails. Narratives acknowledge the importance of continuity. Presented within are new foci of the participants: setting goals, finding a new purpose, and continuing to serve in some capacity. Participants speak about their futures—both their fears and hopes.

Chapter nine concludes the thesis with the key findings of this research. The importance of researching military lives is discussed, with contemplations about the research process. It then addresses the possibilities of future investigation concerning types of rehabilitation. I conclude with some final thoughts about this research, highlight the findings of the data, and reiterate the value of qualitative research about lived experiences following traumatic injury.

Chapter 2: Creation and Destruction: Civilian to Military Service Member and Being Injured

Introduction

The life course is full of transitions, such as adolescence, marriage, or employment, and, sometimes, illness or injury. This research focusses on a transition of going into the military, to the transition out of the military due to a traumatic injury. For the participants of the study, there are three transitions: 1) civilian to military service member, 2) military member to wounded service member, 3) wounded service member to civilian. The literature review of this thesis is ordered in the following sequence: basic training—the physicality of it and the formation a new military identity. Next, I will discuss the experiences of warfare, followed by an overview of transition theories. These theories will aid in understanding normative and non-normative transitions in the life course, and how they are useful for this research. Biographical disruption will be explained before turning to a different type of transition—that of being injured, trauma, and the disruption that it causes. I will discuss traumatic, physical wounds as well invisible wounds.

Transition from civilian to military service member: Creation/construction of the military body and identity

Basic training

To define a military body, one must first understand how that body is ‘created’ from a civilian body. Historical analysis indicates what makes a ‘good soldier’, a man or woman who will behave appropriately, and operate under duress, in different types of environments—most

importantly, in the theatre of war (Marshall, 1947; Grossman, 1996; Peniston-Bird, 2003, Sherman, 2005). As Hale states, 'An individual entering the military is relocating him- or herself from a civilian socio-cultural world to a military one' (2008, p. 306). This 'relocation' begins with basic training, which is the intentional, methodological process of the construction and creation of a military body (Armitage, 2003). The basic training process for any armed forces recruit includes multiple layers of 'deconstruction of their civilian status' and turning it into a military self, (Soeters, Winslow, & Weibull, 2003, p. 250) where 'they are all broken down' and all made to start at the same point (Hale, 2008, p. 319). No matter which branch of national military service one joins, the arrival to basic training is similar: the civilian ceases being an individual and transitions into being part of the military organisation.

There is a transition for both the body and the mind when one joins the military. Leaving the civilian world to enter into basic training involves the creation of a new, altered self and identity. One has, in effect, relinquished their body to the nation-state. New recruits will become one of the many training within a specific time, space, and place: the military institution (see inter alia Moskos, Jr., 1973; Moskos, Jr., 1977; Nuciari, 2003; Hale, 2008; Hockey, 2009; Woodward & Jenkins, 2013). Basic training is a part of the institutionalisation, dictating when the recruit is to sleep, wake, bathe, speak, and all else (Bornmann, 2009). Being 'institutionalised' is a process that can be seen within the public-school setting because of the structures laid forth, such as following a timetable, wearing uniforms, behavioural expectations, and so forth (Goffman, 1961; Foucault, 1997). The following examples illustrate how one can become accustomed to institutionalisation through daily school routines: structured arrival times, uniformed attire, sitting quietly, seeking permission to do an activity, and following an established schedule. Theorists, such as Goffman (1961), Janowitz (1976), and Foucault (1977) assert that the military is a 'total institution', or a particular setting wherein people experience the same sorts of daily routines and experiences, advocated for and run by the nation-state. In particular, Goffman's assessment of the total institution meant that people in everyday life can lack their own space and privacy; there is no 'back stage' for a person's retreat

from the social world (1961). In other words, new recruits are always visible—in the barracks, on parade, whilst eating or resting.

In the military, recruits are constantly watched, performing a new role with rewards or punishments, and building a new sense of self, which is how the military identity is socially constructed. However, more recent work argues that this concept of a total institution overlooks an individual's agency and does not reflect some current military organisations, which allow some form of power (Scott, 2010; Cafario, 2003). Others focus on the military as a 'greedy' institution, wherein the military demands complete time, attention, and loyalty in direct competition with other social obligations, such as the family (Coser, 1974; Segal, 1986; MacLeish, 2013). Nonetheless, it is an institution that teaches bodies and minds to behave in distinctly martial ways.

How one forms the new identity of 'soldier' (or airman, sailor, or Marine) is a process of embodied practices: drills, marching, exercise, and learning to speak a new language related to the branch one is serving within (Hockey, 2009; Bornmann, 2009). It is through this repetitive, somatic process that men and women 'become' soldiers (or airmen, sailors, or Marines). As Kilshaw states, 'The military moulds soldiers through constant exercise, haircuts and uniforms' (2007, p. 255). They are (re)taught how to smell, see, hear, and touch differently in order to accomplish multiple, specific goals: understanding their physical surroundings, working in cohesion, and avoiding being killed whilst under attack in combat (Csordas, 1993; Bornmann, 2009; Hockey, 2009; Higate, 2012; Woodward & Jenkins, 2013). Specifically, in basic training and beyond, 'somatic modes of attention are culturally elaborated ways of attending to and with one's body in surroundings that include the embodied presence of others' (Csordas, 1993, p. 138). These reflexive responses, or 'specific, commonplace and inter-connected sensory practices' (Hockey, 2009, p. 479), are what ensures the correct reaction during warfare for those appropriately trained. Additionally, certain emotions that service members experience, such as anger, serve to create an expected corporeal effect: 'Adrenaline and rage go hand in hand...Anger helps to control fear' (Hoge, 2010, p. 29).

Protevi (2013) articulates that rage can be used on the battlefield to effectively reduce one's behaviour into a 'primitive' state producing endorphins that results from combat and then, like a repetitive cycle, can only be achieved (or relieved) through more combat (p. 131). Newly embodied 'soldierly' skills, along with certain emotions, create the military body.

Learning these new skills to use and interpret their senses forever alters these bodies (Wool, 2013). Training practices—such as controlled breathing while holding, aiming, and firing a rifle—are examples of learning and enacting newly embodied movements (Hockey, 2009; Lande, 2007). The recruit's body is also a social surface upon which a group identity is established (e.g., marching, drill) (McNeill, 1995) and displayed (e.g., uniforms, medals, rank, and, oftentimes, tattoos) (Shilling, 2007; Hale, 2008). Basic training is where civilian bodies and civilian identities are broken down and rebuilt in specific, somatic ways in order to attain membership in the military 'group' (Sherman, 2005; Shilling, 2007; Hockey, 2009). Recruits leave basic training with a newly embodied identity and a sense of collective corporeal belonging as they enter their new role in peak physical fitness and prepared for violence in order to avoid being injured or to save another's life in war (Hockey, 2009).

Experiences of warfare

The 'theatre' of war is about being accustomed to a certain form of violent, expected, and well-practiced bodily behaviours (Csordas, 1993; Bornmann, 2009; Hockey, 2009; Higate, 2012; Newlands, 2013; Wool, 2013; McSorley, 2014). Scarry stated that war is about injury, specifically out-injuring the 'other' side, as well as how warfare allows visions and experiences of abnormal sights: broken, bloody, and open bodies (1985a; 1985b). Whilst the service member's body is trained through repetitive, somatic experiences, such as running with their kit on or firing a rifle quickly and with good aim, it has been argued that their body and mind are not trained to cope with trauma. This psychological trauma can be personal injury, killing others, the deaths of their

comrades, or moral injuries (such as witnessing a civilian's death), which can result in post-traumatic stress disorder (PTSD) and/or extreme physical reactions to sights and sounds for years afterward (Finley, 2011; Sherman, 2015; Wood, 2016; Green, 2016). They may have intense and uncontrolled visceral responses to what are seemingly innocuous 'everyday' occurrences, such as the smell of petrol or hearing fireworks, which sound like—and remind them of—explosions (Shay, 1994; Hoge, 2010; Wead, 2015).

It can often be difficult for civilians to understand what the armed forces experience in combat. With the invention and availability of 'helmetcams' or other body video equipment, glimpses into war-time events are possible. Unlike drones or aircraft cameras that 'see' war from an elevated, disembodied, and slightly abstract viewpoint, helmetcams and other audio-visual recording devices allow the viewer to see and hear the movements, sights, and sounds that the wearer experiences (Norris, 2000; McSorley, 2012). Whether personally, corporately, or governmentally owned, video footage enables the watcher to witness combat from the viewpoint of the service member—the incidences of taking fire, patrolling, and entering into a suspect's home. Hearing the breathing, footsteps, and language used during these incidents allows the viewer to comprehend the surroundings and experiences of combat. This audio-visual framework allows the exploration of embodied combat experiences and how those experiences can reveal their importance prior to injury, especially to those fighting in the extremely kinetic Iraq and Afghanistan wars. Verbal accounts following a deployment highlight somatic capabilities such as using the body's senses to 'feel' if something was awry whilst on reconnaissance, whether on foot patrol or driving (Forbes Tripp, 2008). These exposures to life on the frontline illuminate the extreme risks to daily life and the somatic experiences in the combat zone.

Transitions

Normative transition experiences are expected and happen to every person during a typical life course, for example, ageing, whereas the non-normative is unanticipated and individualistic

(Rice, Herman, & Peterson, 1993; Danish, Owens, Green, & Brunelle, 1997). The events can occur 'on time' (normative) or 'off time' (non-normative), highlighting the importance to a person of being able to predict their life course (Danish, Owens, Green, & Brunelle, 1997, p. 157). The non-normative event could be fairly innocuous, such as the example of unexpectedly leaving a sports team (mentioned below). Limb loss and other severe injury are examples of non-normative, life-altering transitions.

When examining life-altering transitions, such as leaving civilian society to join the Armed Forces or, too, if experiencing traumatic injury, it is helpful to illuminate some theoretical transition frameworks. For instance, Bridges' (2009) framework on managing transitions in organisations consists of three phases: an 'ending' where one must 'let go' of the previous identity, an 'in between time' that allows a person to readjust to the life change(s), and a 'coming out', which is when a new identity forms and the person feels a 'new sense of purpose' (pp. 4-5). Bridges contends that one must acknowledge the past as an ending before being able to move forward, or change, thus creating a new beginning and being capable of transitioning in the life course. In other words, if a person is not allowed the time and space to go through all three phases—letting go, readjusting, acceptance—then the possibility is that they might be fixed in the 'in between'. However, Bridges' research is limiting as it does not incorporate physical change in the examination of how a person might view their identity or the additional embodied psycho-social struggles that may entail.

Based on Bridges' transitional framework, Dima and Skehill's (2011) research adds to what they call 'poverty of theory', asserting that transitions into independent adulthood are deeply complex for care leavers, as the necessary psycho-social adjustments may be quite difficult, or in some cases, be unsuccessful. They argue that 'two different but interconnected transitions—social and psychological—take place at different paces', which can create a 'in-between zone' (Dima & Skehill, 2011, p. 2532). Their research demonstrates that a 'dual transition' exists of both normative and non-normative events (Dima & Skehill, 2011, p. 2537). Simply put, the normative event is

ageing—the end of adolescence—whilst the non-normative is exiting care because it is unique. While the research highlights the need to investigate social and psychological impacts of leaving care into adulthood, the number of participants was not large ($N = 34$) and temporality is an issue as the participants were not out of care, or ‘independent’, for very long (interviewed at only two to four years after leaving).

Schlossberg, Waters, and Goodman state, ‘Transition is not so much a matter of change as of the individual’s own perception of the change’ (1995, p. 28). For Schlossberg and Goodman’s model, three types of transitions exist: anticipated, unanticipated, and non-event (1995, p. 29). Anticipated transitions include retirement or marriage, unanticipated transitions are unpredictable, such as divorce or illness. Non-event transitions are life events that *did not* happen, such as never marrying or having a child, which alters the ‘way they see themselves and might well alter the way they behave’ (Schlossberg, Waters, & Goodman, 1995, pp. 29-30). Whilst experiencing a transition, it is the impact it has on the person or ‘the degree to which the transition alters one’s daily life’, not necessarily the type of event that causes it (Schlossberg, Waters, & Goodman, 1995, p. 33). This framework is pertinent to this research because several participants were quite young when their medical discharge ended their military career. However, there are limitations to this research as it is focused upon psychological impacts of the transition event and not inclusive of any physical aspects that may have caused the event.

Stein’s research on leaving care (2008) claims that it is possible for three phases of social transition to become one ‘compressed’ step and therefore, they lack a true transition.³ Where there should be three distinct steps of transition—‘leaving or disengagement’, ‘transition itself’, and ‘integration into a new or different social state’—there was only one event, or ‘conflation’, where it all happened abruptly upon exit of care (Stein, 2008, p. 40). Stein’s framework for resilience was developed: ‘moving on’ (very resilient), ‘survivors’ (experiencing problems and

³ Stein’s work focused on children ‘ageing out’ of (growing too old to remain in) care in the United Kingdom.

resiliency is dependent on forms of support), and 'victims' (most disadvantaged and had disruptive lives post-care) (2008, pp. 41-43). For example, a higher resilience (or successful transition) occurs when care leavers have positive identities about their personal histories, 'feeling able to plan and be in control', have 'strong social networks', and 'to influence and shape their own biography' (Stein, 2008, pp. 36-38). Whilst differences exist between care leavers and wounded service leavers, Stein's research highlights transitional similarities the two groups may experience during and after the separation from an organisation that has provided many things for them, such as shelter and security, and the issues of leaving that organisation.

Danish et al. (1997) studied sports team and transitions, which is helpful when understanding how injured service members identify with their involvement in the military whilst facing medical discharge. Danish et al. claim, 'Transitions are periods of stress either because life changes are occurring or because predicted changes are not occurring' (1997, p. 156). The concept of 'disengagement' is defined as the act of leaving a team or sport (1997, p. 155). Danish et al. claim that the transition period allows those leaving a team (athletes) to 'review their identity, roles, and motivation to participate in sport. [...] Disengagement occurs within a period of transition' (1997, p. 155). This transition is when the person leaves the team and the sport and is similar to Bridges' (2009) concept of 'in between' time period of transitioning mentioned above.

As mentioned above, the transition theories introduced herein focussed upon psychological or psycho-social aspects that are helpful to the current research. Unfortunately, the theories do not integrate physical, embodied processes of life transitions which is problematic for describing the phenomena of interest. If one is expecting an impending transition, such as military retirement, there can be multiple preparatory steps towards leaving, such as resettlement courses, which can expose exiting service members to learning about finances or writing a resume for future job applications. But unlike service members who retire from the military by choice, those in my research did not have the option of deciding 'whether or not to leave' (Beland, 1992, p. 414),

thereby making their transition multi-faceted.⁴ Whilst one can expect to leave the military at some point in their career, exit via medical discharge is a non-normative event, and transition experiences can be more stressful and compounded due to extensive injuries, possible repeated hospitalisations, lack of familial support, (military) job loss, and a challenge to their identity. This type of unexpected, non-normative event is also known as a 'biographical disruption' when understanding how a person makes sense of their past, present, and future.

Biographical Disruption

Biographical disruption, or a 'life rupture', wherein 'the relations between body, mind and everyday life are threatened' can force people to renegotiate the way they have thought about themselves, their identity, and their relations to others (Bury, 2001, p. 264). Bury's (1982) original research investigating chronic illness built upon Giddens' (1979) previous concept of a 'critical situation', which was focussed upon social disruption in a person's life. Contrary to Bury's (1982) concept of a one-time 'disruption', Taghizadeh-Larsson and Jeppsson-Grassman (2012) claim that illness is not a singular event but rather a series of multiple events that transpire over the life course for those with disabilities or chronic illness. Taghizadeh-Larsson and Jeppsson-Grassman argue that 'complications' and 'functional losses over the life span in chronically ill and disabled people' can be 'both unexpected, feared, and expected at the same time' (2012, p. 1157). This concept creates a future that is 'unknowable' (Wool, 2015), 'uncertain' (Carricaburu & Pierret, 2004), and difficult to imagine (Frank, 1995).

Whilst Bury's concept is mostly about the diagnosis of chronic illness, disablement is another version of a chronic bodily issue, making the concept of biographical disruption helpful in the current research as an analytic framework. Becoming disabled through injury is a 'life rupture'

⁴ For information on a specific group of British veterans called 'Early Service Leavers', please see Caddick, Godier, and Fossey's 'Early service leavers: History, vulnerability and future research', in J. Hughes (ed.) Military veteran psychological health and social care: Contemporary issues (2017); Oxon: Routledge.

and how one incorporates that event into his or her life narrative can be dependent on support systems, extent of injury, and mindset (Pranka, 2018). If a person becomes disabled later in his or her life (as opposed to a person born with a disability), they must learn a new way of living. From basic bodily needs, such as bathing, eating, or going to the bathroom, new modes of movement must be addressed and learned (Smith, 2013). The acquired disability causes a disruption in the 'definition of the self with regard to the individual's past, present and future' (Dickson, Allan, & O'carroll, 2008, p. 409).

Bauman (1992) indicates bodies can fail, McRuer (2006) reminds us that disability awaits us as we age, and Siebers highlights the 'precariousness of the human condition' (2008, p. 5). The moment the service member is traumatically injured is precisely when the precariousness is evident, with long-lasting effects. It is after this 'disruption' that a renegotiation occurs, and a 'reconstructed narrative' will emerge (Williams, 2004). Williams defines reconstruction as 'how people account for the disruption [that] disablement has wrought in their lives' (2004, p. 248). He further explains that the reconstruction is 'an attempt to reconstitute and repair ruptures between body, self, and world' (Williams, 2004, p. 254). As Kelly and Field articulate, 'The body is central both to the experience and feelings associated with illness (self) and in the social processes involved in its management (identity)' (2004, p. 262).

Transition from active military duty to wounded service member: Destruction and disablement of the body

Traumatic wounding in combat

In the theatre of war, traumatic wounding can happen through various forms: bullets, bombs, grenades, and improvised explosive devices (IEDs) to name a few. Each type of combative attack can cause different types of wounds on and within the human body. Medical attempts to save limbs or perform amputations immediately following a battlefield injury can sometimes makes

the wound site more ill or gangrenous, causing multiple amputations—meaning those injured must re-live the experience of loss repeatedly for several years, as well as the physical pain of both the surgery and the healing process afterward (Isaacson, et al., 2010; Stannard, et al., 2011; Jones, 2013). Other post-injury physical issues amputees may face are phantom limb pain or ‘heterotopic ossification’, where bone grows outside of the skeleton and is very painful (Potter, Burns, Lacap, Granville, & Gajewski, 2006; Messinger, 2010). Even the decision to salvage a limb versus performing an amputation can have negative, life-long implications (Harvey, Potter, Vandersea, & Wolf, 2012; Doukas, et al., 2013). The remaining, salvaged limb can be painful, problematic, or need continual corrective surgeries in attempts to ‘fix’ it, wherein the injured person may ultimately opt for an elective amputation (Shephard, 2016).

Many of injured service members who deployed to recent conflicts in Iraq and Afghanistan experience polytraumatic wounding, where more than one site of the body is harmed, impacted, or lost. The increased use of improvised explosive devices in Iraq and Afghanistan meant that an ‘emerging injury pattern’ (Mayhew, 2017, p. 83) of traumatic brain injury (Terry, 2009), ‘lower limb amputation’, and ‘perineal injury’ are the most recent survivable ‘signature injuries’ (Greaves, 2019, p. 252). The increased survivability of these ‘signature injuries’ raises the necessity of understanding the four stages of a bomb blast and its impact upon a body: the first is a shock wave, the second stage is the propulsion of fragments and foreign objects penetrating into the body, the third is the blast, wherein the person is thrown and can sustain fracturing or amputation, and the fourth involves burning, crushing, and respiratory damage (Sayer, et al., 2008). Focusing on the second stage of the blast, it is important to note that the propulsion from the detonation sucks clothing, dirt, and other debris into the body causing major contamination issues in addition to the wounding itself (Sayer, et al., 2008; Bourke, 2014b; Greaves, 2019). Sayer et al. (2008) researched service members who experienced a blast injury and were found to have an average of six issues from the wound (such as a lack of balance, sleeping problems, mental issues and/or eye damage). Pain—chronic or otherwise—ranked as the second most common problem indicating more focus

on pain management would be helpful for this population of injured personnel. Chronic pain, like phantom limb pain, continues for four months or longer because nerves ‘develop a memory’ of pain and will ‘play’ repeatedly within the body, much like a broken record (Cole, Macdonald, Carus, & Howden-Leach, 2005, p. 37). According to Hollander and Gill (2014), the site of a wound is the ‘embodiment of a violent past, which the injured person endures forever, physically and socially’ (p. 220).

The post-2001 combat operations had ‘new and different patterns of injury’ due to IEDs that were increasingly used in Iraq and Afghanistan (Dharm-Datta S. , Etherington, Mistlin, Rees, & Clasper, 2011, p. 1362). There was also an increased number of ‘unexpected survivors’ from Operations Telic and Herrick due to improved—and rapid—medical treatment (MacLeish, 2013; Penn-Barwell, Roberts, Midwinter, & Bishop, 2015; Etherington, Bennett, Phillip, & Mistlin, 2016). For those who experienced traumatic injury in-theatre (whilst deployed in Iraq or Afghanistan), the ‘medical pathway’ intended to have the wounded ‘medically evacuated within one hour, [have] emergency surgery within two hours, and [have] strategic aeromedical evacuation to the UK’ within twenty-four hours (Greaves, 2019, p. 44). This care pathway ensured the injured returned to the United Kingdom quickly to salvage as much of their remaining body as possible (Dharm-Datta, Etherington, Mistlin, Rees, & Clasper, 2011; Roberts & Berry, 2012; Ladlow, et al., 2015; Etherington, Bennet, Phillip, & Mistlin, 2016; Jarvis, et al., 2017; Jones, 2013; Mayhew, 2017). This ‘salvaging’, in turn, allows the rehabilitation professionals to focus on the wounded service member’s return to functionality—with the aim of physical independence, specifically walking (Frain, Bethel, Bishop, 2010; Bricknell, 2014; Ladlow, et al., 2015; Wool, 2015), realising that there may be unknown physical issues over time, including bone growth and circulation issues (Shehab, Elgazzar, & Collier, 2002; Bollinger, et al., 2015; Hinojosa, Sberna Hinojosa, & Ngyuen, 2017).

Lastly, invisible wounds can also be inflicted in traumatic injuring (a bomb blast) or by witnessing something traumatic, such as the death of a fellow service member. Different wars have

produced a history of 'signature wounds' upon the surface of—and within—fighting bodies, such as severe physical burns of British pilots in WWII (Mayhew, 2004) and the psychosomatic 'soldier's heart', 'shell shock', 'combat fatigue' or 'combat stress reaction', which is now known as posttraumatic stress disorder (PTSD) (Shay, 1994; Merridale, 2000; Wead, 2015; Kinder, 2015; Jones & Wessely, 2004; Crocq & Crocq, 2000). Mayhew (2017) asserts that PTSD is 'The stuff of novels, poetry and nightmares', as it includes physical, psychological, and social aspects due to the 'loss of self, grief, and pain (pp. 215-217). Anderson (2011) illuminates the historical view of mental stability within the military, stating that service members who 'broke down during battle were judged "feminine" and unsuitable for military life' (p. 78). A common theme that arose amongst men diagnosed with a mental health issue was the perception that they have a 'feminine' disease. In other words, they were not considered 'true men' because they are not mentally strong (Carless & Douglas, 2017). The past research on posttraumatic stress helped in understanding invisible wounds, such as spinal cord injuries (SCIs) and traumatic brain injuries (TBIs) within the current research. While the increase in posttraumatic stress disorder research has aided in understanding the psychological injuries, very little qualitative research with wounded service personnel exists that explains the lived experiences of post-combat injuries and impending recovery and rehabilitation.

Chapter 3: Re-creation: Rehabilitation, Recovery, and Returning to the Civilian World

Battlefield injury to home

After a service member has been wounded, his or her trajectory is as follows: immediate help from the military medic, evacuation from the scene via helicopter, delivery to in-theatre operation for stabilisation, and then a return to the United Kingdom—all typically within a twenty-four hour period and in a coma-induced state (Greaves, 2019). In this chapter, attention will turn to the transitions facing those injured in combat as well as those service members who were injured in the UK. Due to their injury and subsequent medical discharge, most of them faced similar issues or experiences as service personnel injured whilst deployed. I begin with the literature on military to civilian transitions. Next, the concepts of heteronormative masculinity, stigma, and dependency are examined. I then introduce the concepts and experiences surrounding normal, able-bodiedness, disability, othering, and passing. Issues of pain, legitimacy, stoicism, and support are then discussed. I conclude with how technology, specifically prosthetics, impacts injured veterans.

Transitions from wounded service member to civilian

The previous chapter discussed the transition from civilian to military, specifically through the process of basic training. This section reviews the opposite transition: military to civilian. The military to civilian transition can be difficult under regular circumstances during military retirement. Issues surrounding the military, identity, and transitions have recently been examined and more qualitative data is available on military separation (Jelušič, 2003; Brewin, Garnett, & Andrews, 2011;

Walker, 2012; Cooper, Caddick, Godier, Cooper, & Fossey, 2016; Bulmer & Eichler, 2017; Cooper, et al., 2017; Binks & Cambridge, 2018). Resettlement services are offered in preparation for retiring or the possibility of beginning a second career if the leaver is young (Walker, 2012). Resettlement courses, such as writing a resume or handling personal finances, can be helpful to those who are readying to depart the military, whether through retirement or military discharge.⁵

However, barriers to post-service employment exist because of negative perceptions or biases on the part of the hiring agent (Stone & Stone, 2015), particularly if ex-service members were disabled through their service (Frain, Bethel, & Bishop, 2010). Even when the transition is considered successful by finding a new job or retiring, many ex-service members find it challenging, especially if the veteran continues to identify with their military identity (Higate, 2001; Herman & Yarwood, 2014). Moffatt and Heaven's research on civilians' transitioning into retirement indicates the importance of 'maintaining routines and roles before and after retirement' (2017, p. 881). The concept of consistent routines (Newlands, 2013) helps to explain one reason that able-bodied ex-service personnel might enter the a career involving physical prowess after their military departure (Higate, 2012). Feelings of estrangement and emotional responses such as depression, anxiety, or grief are common for those who have exited the armed forces (Mobbs & Bonnano, 2018; Brewin, Garnett, & Andrews, 2011; Frain, Bethel, & Bishop, 2010; Albertson, 2019). Giddens (1991) claims that transitions always include feelings of loss, as they are a 'series of passages' in the life course (p. 79).

If one still has a 'whole' body, one of the post-military employment options can include following the trajectory of what Higate calls an 'embodied career', such as the private security contracting sector (2012). However, if one has traumatic injuries upon leaving the armed forces, then post-military transition can be quite challenging and will require various sorts of care during

⁵ Examples of resettlement course offerings were given to me from multiple sources: participants, a recently discharged soldier, a private contractor, and a serving Royal Marine Commando at Hasler Company, Naval Service Recovery Centre (NSRC).

the life course (Carless & Douglas, 2017; Herman & Yarwood, 2015, Caddick, et al., 2018; Bulmer & Eichler, 2017). Transitions due to medical discharge can create a sense of uncontrollability (Butler, 1993; Frank, 1995), which requires 'rebuilding' oneself (Elnitsky, Blevins, Fisher, & Magruder, 2017). Exerting agency over self and external factors, such as undesired, unnecessary medication, can be achieved (Messinger, 2010; Mayhew, 2017; Gilleard & Higgs, 2018), creating a continuation of the 'corporeal self' (Allen Collinson & Hockey, 2007).

The military to civilian transition can be difficult after experiencing independence, shared objectives, and deployment, as the service member has been part of a community with a 'collective identity' (von Bredow, 2003). This concept is demonstrated in qualitative research with US veterans returning from Iraq and Afghanistan (Ahern, et al., 2015). Upon military exit, three issues were identified that prevented successful resettlement or reintegration: loss of the 'military family', civilian normality as 'alien', and trying to find a 'new normal' in daily life experiences (Ahern, et al., 2015). It is common for both the veteran and their family to struggle during this transitional time upon returning home, whether it is with a significant other or with parents (Worthen, Moos, & Ahern, 2012). Finding a 'new normal' is a task for all involved (Tanielian & Jaycox, 2008; Lapp, et al., 2010, Worthen, Moos, & Ahern, 2012; Ahern, et al., 2015).

Using Bourdieu's concept of 'cultural capital', Cooper et al. (2017) assert transition issues can stem from forms of capital that are 'embodied and valued within the military institution, including subordination to rank and the symbolism of the uniform, that do not translate into the civilian community' (p. 54). Exiting service members can find it difficult when their values or experiences are not understood and shared. For an example of this later in the life course, de Medeiros and Rubenstein (2016) studied a military retirement community and found a sense of shared bonds amongst the former service members. Within this American communal space, the retired veterans found a continuation of their military identity due to a collective [past] experience within the armed forces. Further, they voluntarily adhered to former protocol by sitting in the

dining area according to previous military rank held (de Medeiros & Rubinstein, 2016, p. 156). In other words, the enlisted personnel did not sit with the officers; they sat with those who shared their enlisted 'past', which allowed a sense of continuity of prior selves, as they could behave and bond as they formerly did.

Masculinity and Stigma

Maintaining independence and control: heteronormative masculinity

Narratives for many wounded in war are built on socially constructed binaries of gender, independence, and strength. Masculinity is 'performed and performative' argues Gilbert (2014, p. 148) and Janowitz (1964) asserts that military masculinity incorporates 'physical fitness', 'breadwinner status', and 'macho social lives' (p. 96). Hale contends that, through the process of militarisation, military masculinities are 'distinctive' because the recruit must learn teamwork and discipline, which set them 'apart from their civilian counterparts' because they must 'defend and fight for one's nation' (Hale, 2008, p. 325). British soldiers who return from deployments with physical impairments are sometimes viewed as emasculated, feminised, and dependent (Anderson, 2011; Gilbert, 2014). Anderson (2011) states an injury that creates disability is 'an emasculating experience, robbing a man of this [masculine] identity and stripping him of his masculine self' (p. 9). Heteronormative masculinity is expected and enacted in military settings, even in the rehabilitation space, through stoicism, strength, and 'soldiering on' (Csordas, 1993; Higate, 2003; Lande, 2007; Carless & Douglas, 2017; Basham, 2013; Hockey, 2013; MacLeish, 2013; Bulmer & Eichler, 2017).

Masculinity and post-injury sexual functioning

Concerns surrounding heteronormative masculinity, through sexuality and reproduction, are also interlaced with injured veterans' stories in Walter Reed, the US Veterans' hospital. In an

example of perceived loss of virility and stigmatisation, a young soldier's mother reported how worried she was about his future ability to have sexual relations and to procreate, but the staff at Walter Reed seemed unwilling to address this in a pro-active fashion (Wool, 2015). In lieu of therapies or extensive dialogue, the medical team's response to address the issue was to give pills such as Viagra, Cialis, and Levitra to anyone mentioning sexual dysfunctions, problems, or concerns (Wool & Messinger, 2012; Wool, 2015). Belief that medicine was the answer provided an iatrogenic approach when dealing with military service members – both in-theatre and at home. This practice was the 'new normal', causing addiction and inability to personally interact as one used to (Boggs, 2015; Jones, 2013; Wool, 2015). Procreation and sexuality were so important that in-theatre medical staff went to extreme measures in order to retain as much of a young soldier's genitals as possible. This reaction is acknowledged with a military surgeon stating, '[I] had never seen anything like it. To have to amputate that boy's penis and watch it go into the surgical waste container—it was emotional' (Jones, 2013, p. 42).⁶

Stigma

Stigma arising around an altered and newly disfigured body can occur for those wounded in war. Stigma, according to Goffman, is when a person is perceived as deviant from societal norms and is seen as abnormal, unnatural, and excluded based on this perceived difference (1961). The concept of stigmatisation incorporates 'discredited versus discreditable' in society, as put forth by Goffman. According to Goffman, if a difference (such as an injury or disability) is 'evident on the spot', it instantly discredits the person by people around them. However, if they can pass or 'masquerade' without the difference being detected, they are on the edge of being 'discreditable'

⁶ For more on British surgical teams dealing with genital injuries at Queen Elizabeth Hospital, see: www.gq-magazine.co.uk/article/wounded-soldiers-taboo-british-surgeons. The article states, 'There is a poignant contradiction in regards [sic] to the fact that one's genitals aren't necessary for maintaining life, yet for so many, they are entirely vital for living a certain quality of life.'

because 'his differentness is neither known about by those present nor immediately perceivable by them' (1963, p. 4; 97). The choice, according to Goffman (1963), is 'to display or not to display; to tell or not to tell; to let on or to not let on; to lie or not to lie; and in each case, to whom, how, when, and where' (p. 41). Reasons behind displaying one's disability (or not displaying it) can be due to the social capital and privileges they may have previously held.

Stone and Stone (2015) argue that stigma is a 'deeply discrediting negative characteristic' (p. 70), which affects a person's experiences of interactions with others. Occurrences of prejudice can enter into a stigmatised person's daily life due to having become different, especially if there are 'bodily betrayals', which can be a bodily function that is not supposed to be witnessed, such as incontinence (Howson, 2004; Seymour, 1998). These uncontrollable experiences make evident the disabled body, which can further cause stigmatisation through rejection, exclusion, and other negative societal reactions (Scambler, 2009; Vickers, 2017).

Stigmatised dependency

Accepting charity or being seen as dependent can be perceived as undesirable, and thus rejected, both in qualitative research and this current research. Historically, dependence upon the nation-state was stigmatised, and can be seen in the work of eugenicists (Galusca, 2009; Waldschmidt, 2005; Carey, 2013; Dixon, 2014). Further, dependency is viewed as a type of deviancy within capitalistic societies (Bury, 2004; Waldschmidt, 2005; Galusca, 2009; Anderson, 2011; Stone & Stone, 2015). Kinder (2015) argues that disabled veterans are socially stigmatised due to dependency issues because, 'To a growing number of observers, ex-soldiers' reliance upon government assistance figured them as inadequately independent and, by extension, insufficiently manly' (p. 34). Able-bodiedness, independence, and heteronormative masculinity are, at times, inextricable for injured men. Whether a civilian attacked by soldiers in Uganda (Hollander & Gill, 2014), UK soldiers who have experienced Gulf War Syndrome (Kilshaw, 2007), or injured Turkish

and Lebanese veterans (Aciksoz, 2012; Hartley, 2013), there is a continued battle against being associated with the stigma surrounding being categorised as effeminate, weak, dependent (either physically or financially through welfare benefits), or having lost virility.

Describing injured civilian Ugandan men as having 'marked bodies', Hollander and Gill (2104) assert that the war-injured male body exists in binaries: one of their independent, masculine past, where the men were 'strong, virile, (and) a responsible member of his community' versus their present, which consists of 'being a dependent' (p. 225). In research done with Turkish veterans, many ex-service personnel vocalised that they refuse to be viewed or labelled as disabled (Aciksoz, 2012). Due to the high number of disabled and disfigured beggars in public spaces, former service members are highly resistant to being thought of as similar to the people who had been disabled from birth. One Turkish veteran was explicitly angry about being associated with a disabled person (beggar), as '[S]tigmatas attached to disability deeply hinder people with disabilities from education, employment, marriage, and political participation, and reduce them to subjects of charity' (Aciksoz, 2012, p. 15). Similarly, disability narratives collected in a Lebanese rehabilitation hospital, being disabled through a war injury carried a status of privilege, bravery, and a sense of heroism for veterans but not the civilians who were also injured during warfare (Hartley, 2013). Those interviewed in Lebanon shared a sense of meaningfulness about their disability precisely because they were war-wounded. After fighting for his country and being injured during that military service, it was important for the veteran narrative to retain a privileged (masculine) place within his society.

Societal constructs: Normal able-bodiedness, disability, othering, and passing

In this section, we will turn our focus to the social constructs that surround bodies. Societal categorisations are viewed as such: a person is either abled or disabled; a person is one thing or

another, but not both. As Porter (1994) claims, '[P]eople are cleaved into two categories—disabled and abled—each representing not different places along a continuum but different kinds of people' (p. 71). In order to prepare for the empirical chapters, it is important to pause to introduce terminology and concepts. We will be discussing what is meant by normal ablebodiedness (McRuer, 2002; Galusca, 2009; Siebers, 2008), disability (Oliver, 1990), and 'othering' (Ewing, 2002; Deal, 2003; Siebers, 2008). Additional concepts engage 'passing' as normal (Siebers, 2008) in order to avoid stigmatisation (Goffman, 1963). Ewing states, 'Most people with disabilities do not want to be thought of as disabled' (2002, p. 74). It is important to note that disability is a social construct as well as being physically structural within the built environment; people can be disabled by their surroundings, such as buildings without wheelchair ramps (Hahn, 1985).⁷

'Normal' able-bodiedness

The concept of normality or of being perceived as a normal, able-bodied person is socially constructed and institutionalised, both within society's behaviours and physical structures (Barnes & Mercer, 2003; Oliver, 1996; Goffman, 1963). Being an able-bodied, physically fit person is a requirement to enter into the military institution.⁸ Normal able-bodiedness is a concept that 'originate(s) in a process of enforcement' (Galusca, 2009, p. 151) through a 'dominant system', which is enacted through 'social, relational practices' (Carey, 2003, p. 424). Further, McRuer (2013) labels this normative, dominant system as one which is a 'system of compulsory able-bodied-ness', which creates disability (p. 370). In other words, society encourages 'normality' through appearing to have an able body that is capable of being physically independent. Goffman (1963) asserted these 'routines of

⁷ An example of a structural issue is when someone in a wheelchair is unable to enter buildings that have stairs as an entrance, or when people park their cars on sidewalks, forcing the person in a wheelchair to use the road.

⁸ The British Army requires passing a Fitness Test, going through a 'range of strength and stamina tests, as well as a run.' From: <https://apply.army.mod.uk/how-to-join/can-i-join/fitness>

social intercourse in established settings allow us to deal with anticipated others without special attention or thought' (p. 2).

Disability

Disability is typically defined medically in terms of physical, emotional, or intellectual impairments rooted in the person and hindering normal functioning across a wide variety of settings (Hahn, 1985). Similarly, the World Health Organisation's 1980 model situated disability within the person, wherein impairment, disability, and handicap are different. Impairment is defined as 'an abnormality in the structure or functioning of the body', disability is 'activity restriction', and a handicap is a 'social disadvantage' (Williams, 2000, p. 47). Oliver (1990), however, argues that disability is not rooted in persons with disabilities, but instead arises from interactions between persons and their environments. Laws have been put in place, making it that environments, such as train stations or schools, must include accommodations for persons with disabilities. Oftentimes these adaptations are added as an obligatory afterthought, which does not always accomplish its goal of making a physical space usable for someone with disabilities. Siebers (2008) claims that disability is a cultural identity. Other authors focus on the 'marked-ness' of the body, which differentiates people in the 'system' of dis/ability (Garland-Thomson, 2002; Hollander & Gill, 2014). Garland-Thomson (2017) further describes disability as such:

Disability's indisputably random and unpredictable character translates as appalling disorder and persistent menace in a social order predicated on self-government. [...] The disabled body stands for the self gone out of control, individualism run rampant: it mocks the notion of the body as compliant instrument of the limitless will and appears in the cultural imagination as ungovernable, recalcitrant, flaunting its difference as if to refute the fantasy of sameness implicit in the notion of equality. Even more troubling, disability suggests that the cultural other lies dormant within the cultural self, threatening abrupt or gradual transformations from "man" to "invalid" (p. 43).

Disability is not (just) medical; it is social (Chockalingam, Thomas, & Duval, 2012), where if one is not able(d), they are different—the 'other'—the person with disabilities.

Othering: How society 'others' persons with disabilities

'Othering' by persons without disabilities can occur because 'disability serves as an unacknowledged symbol of otherness rather than a feature of everyday life' (Siebers, 2008, p. 6). Static societal expectations, Carey (2013) argues, 'constrain the content of the (identity) categories, offering narrow views of behaviour, attitudes, and lifestyles associated with an identity' (p. 144). Siebers asserts that 'able-bodiedness is a temporary identity at best' (2008, p. 5), pointing out that disability identity is part of being human. In other words, it is not uncommon to have some physically disabling occurrence happen—either temporarily or long-term—that can change a person from abled to disabled in an instant. For example, experiencing a car accident could either cause a temporary disablement, such as breaking a leg, or it may cause a permanent one, such as paraplegia.

It is possible that people with disabilities can view each other differently (Ewing, 2002; Deal, 2003) and an 'othering' process can occur amongst people with different types of disabilities. For instance, the term 'SuperCrip' was designated by persons with disabilities who could *not* perform extremely physical, athletic feats to describe those who could (Deal, 2003). An example of a 'SuperCrip' is someone who, 'by sheer force of will manage[s] to "triumph" over their disabilities', thus accomplishing 'extraordinary success' (Kinder, 2015, p. 285). This differentiation, or 'othering', within a group also indicates a type of hierarchy of abilities (or lack thereof). Research supports this 'hierarchy of impairments', where it is found some forms of disability are more acceptable in society (Tringo, 1970; Thomas, 2000; Deal, 2003; Stone & Stone, 2015). Tringo's research (1970) found that one of the least acceptable was mental illness. This 'hierarchy', which can be found in collective rehabilitative settings, such as the military rehabilitation space, can bring about positive changes in a person's perspective about their injury because they realise the varying degrees of injury (Carless & Douglas, 2017).

Passing as normal

Passing ‘refers to the way people conceal social markers of impairment to avoid the stigma of disability and pass as “normal”’ (Brune & Wilson, 2013, p. 1). Some people with disabilities desire to pass. In order to accomplish ‘passing’, one must have a convincing, socially acceptable performance of normative behaviours, movements, language, and appearance, which may negate having what is designated as a ‘spoiled identity’ (or being stigmatised) (Goffman, 1963; Ewing, 2002; Howson, 2004). Siebers (2008, p. 101) defines ‘passing’ as such:

Passing preserves social hierarchies because it assumes that individuals want to rise above their present social station and that the station to which they aspire belongs to a dominant social group. It stamps the dominant social position as simultaneously normative and desirable.

Siebers, however, complicates the idea of a binary (passing or not passing) into a useful tool for narratives: ‘disguise’ or ‘display’ (2008, p. 100). There are some persons with disabilities who have a choice as to whether to reveal their disability or not. For example, some amputees can ‘display’ by wearing shorts year-round so people can see their prosthetic leg. Alternatively, some opt to ‘disguise’ a prosthetic leg by wearing trousers, which would cover and conceal the prosthetic. However, Rembis (2013) argues that passing is not only about disguising or ‘physically concealing’, but ‘depends on how well one can approximate the gendered, white, heterosexual, nondisabled norm and meet societal expectations for conduct, appearance, and performance’ (pp. 112-113). Carey (2013) further highlights the importance of societal norms and states that passing incentivises ‘the desire to preserve the exclusive privileges conferred on these defined as fit,’ and that ‘tremendous anxiety about and fear of “passing” is expressed by professionals and elites.’ (p. 145).

This intersubjective, visual encounter—‘passing’ as normal—when interacting with society is important if one does not wish to be ‘othered’ (Goffman, 1963; Grosz, 1994; Bandura, 1999; Siebers, 2008). As Hollander and Gill put forth, ‘[T]he body predicates, or at least influences, the

quality of interaction a person has. These interactions, defined in terms of social capital networks, determine the level of (re)integration in society' (2014, p. 230). Research on embodiment and in/visibility highlights how one can seek to 'fit in' and gain social capital (Dolezal, 2010). The gaze of others can produce self-policing of one's appearance so that in blending in with societal norms, one passes as normal (Dolezal, 2010) (see also (Foucault, 1980)).⁹ For instance, whilst on active duty, service members are both invisible and visible. Together in their matching uniforms, they appear as a mass, relatively indistinguishable from one another to the civilian eye.¹⁰ If the uniformed service member goes out amongst civilians, they immediately become visible; they are the 'other' in a civilian society. Therefore, they are unable to 'pass', in this case, as normal (a civilian) but are set apart. Dolezal's work can also be useful when thinking about injured veterans who have become highly visible in society due to wounded and altered bodies, especially those with limb loss or other physical disfigurement (Murray, 2005; Messinger, 2010). Their social capital must be renegotiated as they move through daily life occurrences and unavoidable intersubjective encounters.

Social encounters can cause long-lasting repercussions for a person who has visible differences or disfigurements. Discrimination and stigmatisation can cause negative emotions and negative self-image (Stock, Whale, Jenkinson, Rumsey, & Fox, 2013). Research suggests that possible reactions to disfigurement can be quite negative (Stock, Whale, Jenkinson, Rumsey, & Fox, 2013).¹¹ Stock et al.'s research should be considered in wounded veterans' perceptions of social interactions immediately following their injury. When attempting to understand the reintegration

⁹ Dolezal's research focused on women in Western societies and their internalised desire to conform to socio-cultural standards via cosmetic surgery.

¹⁰ Basic Training assisted in instilling this need for 'aliqueness'—both bodily and mentally—in order to function as a proper team.

¹¹ An initial reaction of being scared when presented with images of people with facial disfigurements due to media portrayals of villains because 'the bad characters have some sort of facial disfigurement' is not unusual (p.46). Interestingly, the United Kingdom's Channel 4 ran an advertisement about the Rio 2016 Rio de Janeiro Paralympics competitors specifically addressing this negative perception of persons with disabilities being 'villians'. Originally seen on 14 November 2015: <http://creativity-online.com/work/channel-4-the-superhumans-return/44184>.

into civilian society and rehabilitation process for wounded ex-service members, it is helpful to remember their previously embodied status, independence, and ability juxtaposed to an altered, injured body that might need functional assistance, which may not be able to 'pass' as a normal, able-bodied person.

Pain, legitimacy, and stoicism

Narratives of pain after injury can be difficult to classify because not everyone experiences pain the same way and it is difficult to articulate (Scarry, 1985b). Fordham and Dunn (2014) argue that pain is a 'subjective experience which cannot be adequately defined either by the stimulus or the response of humans', (p. 32). There are multiplicities of pain, some of which are easily understood and can seem legitimate to others. In other words, people can readily understand or 'legitimise' a pain they can see (or may have had before), such as a surgery scar or a cast over a broken bone. These variations of pain can be recognized as having a physical origin or reason for the pain, and therefore deemed legitimate (Atarodi & Hosier, 2011). When the pain stems from something that is not as apparent or easily seen, such as traumatic brain injury (TBI), posttraumatic stress disorder (PTSD), or phantom limb pain after an amputation, it becomes much more complex to understand or treat. This type of pain is psychogenic in nature and frequently believed by others, such as carers or medical practitioners, to be illegitimate pain in the sense that it is not as acceptable without a clear, physical origin causing distress to all involved (Kenney & Slowey, 2010; Fordham & Dunn, 1994). This negative reaction by carers is also due to a lack of proper explanation given to them by health care providers with regard to dealing with a person who has psychogenic pain (Schaller, Liedberg, & Larsson, 2014).

Scarry's work emphasises the problem that there is no accurate language in describing pain, as it occurs within the individual's body, and without proper language it is difficult finding reliable forms of treatment (1985a; 1985b). When one does communicate, 'pain articulation' can affect

diagnosis if the patient is perceived as either under- or over-articulating their pain. Bourke asserts that it is the medical practitioner listening to the description who legitimatises the pain (2014a, pp. 143-145). Acknowledging tension in communications between practitioners and patients with disabilities might also be applicable to a service member who leaves the military medical system, that is familiar with the types of war injuries, entering the National Health System (NHS), which is unaccustomed to treating war wounds or the necessary rehabilitation.

Pain for injuries and amputations can exist for years beyond the date of injury—sometimes lasting throughout the entirety of the wounded person's life (Sherman & Sherman, 1985; Tarr & Thomas, 2011; Esquenazi, 2002). Many who experience pain, inclusive of phantom limb pain, experience a lack of credibility or inability to accurately describe pain when reporting it (Sherman & Sherman, 1985; Kenney & Slowey, 2010; Grabois, 2002; Bourke, 2014a). Additionally, there is a desire to hide pain or depression because it is viewed as effeminate and therefore is commonly handled with a silent stoicism (Frank, 1995; Sherman, 2005; Oliffe & Phillips, 2008; Atarodi & Hosier, 2011; de Medeiros & Rubenstein, 2016).

As Bourke states, 'A pain-event always belongs to an individual's life; it is a part of her life story', but it must be 'named' for others to understand it (2014a, p. 5). For example, phantom limb pain is experienced by many who have undergone an amputation. Phantom limb pain is different than residual limb pain, as it—the phantom limb pain—occurs where the limb used to exist but is no longer there. This 'phantom' pain for amputees can be very disturbing and 'just as real and perhaps more frustrating and frightening to the sufferer than many other pains' (Fordham & Dunn, 1994, p. 41). Furthermore, prosthetics can be painful to the residual limbs, not fit well, and need repairs or replacement over time (Resnik, et al., 2012). If pain is not able to be controlled, especially at the point of injury, it can cause many more issues, such as 'post-traumatic stress disorder, depression, sleep disturbances, and chronic pain syndromes' (Blackbourne, et al., 2012, p. S380).

Residual and phantom pain are not as easy to identify as the loss of a limb, so it is crucial to investigate these somatic issues and give voice to the person experiencing pain.

Importance of support

Support appears to have a major impact upon the psycho-social and physical rehabilitation of injured service members. For instance, in the form of first-line of support, nurses' interactions with the wounded during the first few days after injury has a highly positive impact for successful patient recovery (Benetato, 2011). Camaraderie with others is found in rehabilitation, such as mutual bonding and sociality (Dickson, Allan, & O'carroll, 2008; Kleinman, 1989; Anderson, 2011; Hartley, 2013; Mayhew, 2017; Wool, 2017; Hollander & Gill, 2014) and humour (Hinojosa, 2010; Anderson, 2011; Gilbert, 2014; Wool, 2015; MacLeish, 2013; Kinder, 2015; Caddick, 2018). Identity and belonging can be affirmed or reshaped via involvement with veterans' groups or organisations, which in turn can increase the feelings of support (Luhtanen & Crocker, 1992; Thompson & Fisher, 2010; Krull & Oguz, 2014; Bourke, 2014a; Wool, 2013). Social, familial, and peer support can psychologically empower the ex-service members against the possible negative experiences such as financial loss and depression, as well as assist them on the transition to civilian life (Worthen, Moos, & Ahern, 2012; Ahern, et al., 2015). Other support mechanisms involve assisting veterans transitioning into higher education (DiRamio & Spires, 2009; Wheeler, 2012). Due to the ease of access, multiple venues of electronic communal support, such as video (Skype or FaceTime), emails, and other internet-based interactions, can serve as spaces of psychosocial support to persons with newly acquired disabilities (Thompson & Fisher, 2010; Bourke, 2014a).

Conversely, a lack of support can exist upon exiting the military. Some severely wounded amputees may become resigned and depressed without proper support networks. Those who lack support or continue experiencing pain can have more difficulty reintegrating into life (Thompson & Fisher, 2010). Upon being released from the UK Armed Forces, the veteran returns home and can

rely upon relatives, neighbours, or others for assistance. Some service leavers might be within a lower socioeconomic level wherein they might face recovery and reintegration issues due to smaller support networks (Lewis, DiGiacomo, Currow, & Davidson, 2014; Aciksoz, 2012). This smaller support network can be due to the carer's need to work or the veteran living far away from familial support. If the veteran has no live-in carer, the loss of feeling socially connected due to disability or disfigurement is particularly felt by those who live by themselves. For former service members, this could mean they have little-to-no interaction with those whom share a similar past of being in the armed forces (Lewis, DiGiacomo, Currow, & Davidson, 2014). However, those with family carers will have a stronger support network during rehabilitation and after medical discharge.

Carers

The importance of the roles that family, social connections, and community resources play in caregiving and health outcomes is significant for people who are injured or face illness (Lewis, DiGiacomo, Currow, & Davidson, 2014). These roles influence the quality of care for the ill person and reflect the strength of support they receive at vital times in life, varying from emotional support, delivery of food, and transportation to appointments. For instance, a 'Non-Medical Attendant' program in the US pays family and non-family members to care for an injured soldier. Wool and Messinger (2012) examine the responsibilities and expectations that the US military placed upon family or close friends of severely wounded service members in the Walter Reed hospital. These caregivers usually come from jobs, families, and communities that are far away from the location of Walter Reed, making the management of conflicting responsibilities quite difficult for the duration of their wounded soldier's rehabilitation. In short, these non-medical attendants (NMAs) are paid for their work but must turn in a timecard as well as request permission to come and go from the hospital for any length of time.

Among the many responsibilities the NMAs had were to ensure the soldier was compliant in attending various therapy sessions, which could be at odds with what the soldier desired thereby placing the NMAs in an unenviable position. Therapists viewed the NMAs as a source of motivation and instigation—that they should always push their ‘soldier/patient’ to do therapy. Some of the other tasks an NMA is expected to fulfil are overnight supervision of ‘soldier/patient’ (for preventing accidental death or suicide), paperwork, picking up prescriptions and mail, and more. Sometimes the duties of caring crossed over into the medical domain, as the authors indicate the NMAs ‘[h]elp to change wound dressings, catheters, and colostomy bags’ because they loved their soldier/patient and not because it was seen as an aspect of the paid position of an NMA (Wool & Messinger, 2012). It is possible that carers of medically discharged UK service personnel also face these types of responsibilities, albeit at home.

Technology: Prosthetics and independence

Prosthetics and sport

New technology and prosthetics can also be mentally reassuring for the wounded amputee to regain a sense of identity, control of his/her body, increase his/her ability for sports participation, and lower chances of post-traumatic stress (Doukas, et al., 2013; Harvey, Potter, Vandersea, & Wolf, 2012). Technology can enable people with disabilities and give them independence, such as creating a smart phone for people without fingers, or other activity-focussed prosthetics¹² (Serlin, 2015; Sydell, 2016; Geil, 2017). Melissa Stockwell, a US veteran, states the loss of her left leg and its replacement by a prosthetic is a ‘badge of honour’; she indicates, ‘I’ve done more with one leg than I ever would have done with two’ (Wolff, 2011, p. 18). Stockwell qualified for the Paralympic Games and was the first veteran from the Iraqi conflict to attain this status. Other veterans in recent years have benefitted from improvements in technology in ensuring fit and quality of use

¹² Specially designed prosthetics can be created for activities such as running, golfing, or skydiving.

for their prosthetics as ‘wearable robotic devices’ (Wolff, 2011, p. 19). This advancement in prosthetics can privilege many veterans ahead of civilians who experience an amputation, as insurance companies may not be willing to pay the price for newer technology; also, insurance may only cover the price of one prosthetic (e.g., one artificial arm) for the duration of the person’s life (Wolff, 2011).

Technology creates the space for a new, powerful type of human, the ‘cyborg’ (Haraway, 1991). Siebers (2008) asserts that this concept of cyborg as only powerful, never in pain or with problems, denies the reality of being disabled. Additionally, Caso (2016) investigates the ‘sexing’ of prosthetic-wearing ex-forces—mostly male—who posed, nude, for a ‘large-scale coffee-table art book titled *Always Loyal*’ (p. 218). Caso argues this enables the disability hierarchy between those who have mental injuries, which are not photographable, and physical injuries, which are presented in a ‘re-masculinised’ and ‘sexually powerful and technologically enhanced’ fashion (2016, p. 219). Masters (2005) asserts these are ‘cyborg soldiers’; according to Caso, are the ideal of ‘post-human techno-masculinity’ (2016, p. 219), which redeems the state and society that sent them to war. Further, prosthetics enable people with disabilities to be labelled ‘SuperCrips’, who are Paralympians and others who achieve physical feats. However, it is argued that they, like the ‘cyborg’ human or soldier, may be able to hide issues surrounding disability (McRuer, 2006; Siebers, 2008). In this fashion ‘SuperCrips’ reiterate physical achievement and success rather than day-to-day issues or socio-structural barriers.

Elite sport

Many wounded veterans are young and athletically fit prior to their injury, so sport as an avenue of rehabilitation and focus can be beneficial (Chockalingam, Thomas, & Duval, 2012; Brittain & Green, 2012; Green, 2014; Carless, 2014; Shirazipour, et al., 2017). Practitioners in rehabilitation settings believe that sport can ‘connect patients...to their pasts as service members’ (Messinger,

2010, p. 282). Doukas et al. claim that an amputee can have a lower chance of post-traumatic stress with increased involvement with sport (2013). Other research indicates sport or recreational therapy can be a form of positive reintegration or transition into the civilian world (Goff, 2012; Chockalingam, Thomas, & Duval, 2012; Caddick & Smith, 2018). They can put to use their prior abilities and training towards a rehabilitation that includes sport or elite sport, such as the international Paralympics, the UK Invictus Games, or USA Wounded Warrior Games (Chockalingam, Thomas, & Duval, 2012; Hawkins, 2011). A form of the Paralympic Games was originally begun for wounded WWII veterans in the UK, the 'Stoke Mandeville Games', but continue today to include various persons with physical disabilities (Reznik, 2008; Anderson, 2011; Goff, 2012; Chockalingam, Thomas, & Duval, 2012). As Rembis (2013, p. 117) notes, athletes with disabilities can use sport '[I]n a staged setting that involves elaborate displays of physicality and, perhaps more important, dominant notions of heteronormative nondisabled masculinity and femininity' and are allowed to pass as normal. Rembis troubles the idea of passing, stating that it is 'simplistic and misleading' to believe that people with disabilities can overcome them via sporting competitions (Rembis, 2013, p. 116). Along with the help of the British Paralympic Association, British military charity organisations assist former service members in training for the Paralympics (e.g., the Rio paratriathlon or Tokyo's para-powerlifting team) after competing in the Invictus Games (Shephard, 2016).

Independence via 'Smart homes'

Incorporating technology to provide masculinised independence for a disabled veteran can be accomplished within homes. In the US, for example, a limited number of quadruple amputee veterans could receive a new 'Smart Home' that enables them to be relatively independent through a technologically advanced home (Serlin, 2015). Serlin states only a very small percentage of veterans qualify or receive these mechanized, high-tech 'cybernetic system' residences, which can be viewed as an extension of the technology they experienced within the (masculine) military

institution. In some instances, these homes can also serve as a way to physically isolate them from the larger community (2015). Whilst most US veterans receive a modest amount of financial assistance to make renovations to their current home, only those deemed most injured receive a brand-new smart home by private military organisations (Serlin, 2015, pp. 42-43). Serlin (2015) argues that providing an autonomous home is a way for a disabled male veteran to regain his masculinity, thus recreating the heterosexual male's place in society (i.e., to have an education, a job, and a home). The return to these heteronormative ideals is pervasive for men wounded in war (Berghs, 2008).

Conclusion

The literature discussed herein highlights the necessary inter-relationship of multiple disciplines' concepts and theories. Transition research and theories investigate physically able-bodied experiences during the life course. Whether it is retirement or leaving care, it is informative to understand those experiences. Additionally, disability research emphasises people born with a disability as well as others who are non-normative, and the relationship with society. This information is vital when analysing the lives and identities of people who acquire disabilities. For example, injured persons might experience stigma or 'othering', increasing a desire to 'pass' as 'normal'. Alternatively, 'crip' theory demonstrates the desire to both recognise and respect disabilities. Research about ageing and dependency also incorporates physical issues during the life course. Furthermore, literature concerning chronic illness and biographical disruption is illustrative of the multiple ways one event impacts all other aspects of life, including family members or carers. Psycho-social dimensions of military service and combat are addressed within studies about the armed forces, which highlight—but are not limited to—institutionalisation, habitus, pain, and posttraumatic stress. Lastly, the effects of polytrauma and wound salvaging aid in comprehending an altered physical state of being and functionality.

Chapter 4: Methodology

Introduction

In this chapter I will explain the type of research carried out and the process behind it. Beginning with the research questions posed, I will then explain the methodological underpinnings and chosen research method of narrative inquiry. A discussion surrounding illness narratives and meaning-making will follow, including the importance of personal storytelling. I will then discuss the research design, interviewing, the interview schedule, and participant criteria. The recruitment process is then presented, discussing the various forms of cultural immersion and recruitment methods. I present the participants, including the year they were injured, the injury type, country where injured, the cause of injury, and the branch of military wherein they served. This information is followed by the data collection, storage, and analysis. I will move on to the ethics and risks surrounding my research. Military research methods are then covered. Next, I reflect upon my positionality within this research and conclude with a brief summary of the chapter.

Research Questions

In the previous chapters, I have discussed the available literature on the creation and destruction of the military body, followed by the recreation of an altered, post-military body and identity. Acknowledging the life-long implications for a wounded body involves time and space for understanding the negotiations that may have occurred for the veteran. Gaining insight into life after injury can illuminate pathways for others who might experience the same type of physical loss but by different means (someone who has a car accident whilst driving their car versus an improvised explosive device whilst on a deployment). Investigating how one negotiates identity

and embodiment after suffering a traumatic wound could also benefit those who help the injured: carers, family members, practitioners, friends, and employers. It is the intent of this research to help fill the lacuna and to bring peripheral experiences to the centre of discussions and ideas about ex-military bodies that have become disabled through injury, as well as the longer-term ramifications of the types of injury incurred. With that in mind, this research focussed on the following principal questions concerning embodiment and identity:

- How does an able-bodied person transition in life after experiencing a sudden and traumatic injury whilst serving in the British Armed Forces?
- How does one make meaning of his or her life experiences following this injury?
- How does the injured service person meaningfully integrate their past, present, and future into a coherent narrative?

With these questions in mind, I chose the method of narrative inquiry for my research.

Research Method: Narrative Inquiry

Stories and narratives

This research focuses on stories and narratives. Narration allows a person to tell his or her life story, typically in such a way where there is a clear and continuous linkage to the past, present, and future; this is known as ‘autobiographical reasoning’ (Habermas & Kober, 2015). Stories are a ‘sequence of events’ (Squire, et. al, 2014, p. 23) that can serve as accounts of ‘telling about the past’ or ‘developing or expressing personal identity’ (p. 6). Stories, asserts Caddick (2018, p. 4) have ‘characters’, an ‘event’, and a ‘plot’ that can ‘represent the complexity, ambiguity, and sense of “life-in-flux” of being human’. ‘[T]he act of narration that structures and projects our sense of selfhood and identity over time, along with the tellability of personal stories, is an embodied process’ (Smith & Sparkes, 2008, p. 219). Frank’s (1995) ground-breaking work (found below) about illness narratives describes learning to ‘think with stories’ (p. 23) and specifically about ‘the stories

told *through* suffering bodies' (p. 24; emphasis in the original). As Charon states about the temporal nature and inter-relatability of our stories (2006, p. vii):

When we try to understand why things happen, we put events in temporal order, making decisions about beginnings, middles, and ends or causes and effects by virtue of imposing plots on otherwise chaotic events. We hail our relations with other human beings over time by receiving and alluding to stories told by others—in myths, legends, histories, novels, and sacred texts.

Frank highlights this interaction with previous stories we hear and we tell, indicating that '[a]cting and telling stories about actions are thus iterative, not sequential; each builds on the other' (2014, p. S16). Additionally, Frank (2004) argues that we can become someone different by listening to stories' claims. As Frank (2004 p. 211) indicates, we use frameworks as listeners, moving from thinking 'about' to thinking 'with':

Frameworks facilitate thinking *about*. Without a framework to contain it, a story can be easily dismissed as a one-off occurrence, a sad tale that has little claim on the listener. Claims can be instrumental, calling on the listener to do something, but the more consequential claims require the listener to become someone different, to understand his or her place in the world differently, because he or she now exists in a new web of relationships. When the story's claim becomes personal, thinking shifts from *about* to *with*, and the framework that enabled the initial listening can fade into the background (emphasis in original).

Frank asserts that 'stories *do* things; they *act*' and are 'performative' because the 'storytelling does something' (2010, p. 40). Frank further opines, 'Yet like all actors, stories make a difference in relation to other actors, and exactly what difference they will make can never be predicted' (2006, p. 423). But it is this unpredictability that makes it possible for stories and their tellers to create change in the world—becoming someone different or behaving differently upon hearing a story—that can change a story into something bigger than itself.

Squire et al. differentiate stories from narratives, as narratives are the 'organized, plotted, interpreted accounts of events' (2014, p. 7) that 'generates meaning', 'progresses' and 'does not only expound, but explains' (p. 5). Narratives can also allow 'analysts access to an individual's

internal mental state, identities, senses of self and real, lived experiences. As such, researchers seek to explore the interiority of people and uncover their inner world via the stories they tell' (Smith & Sparkes, 2008, p. 9). Whilst stories can entertain us, describe us, or guide us, narratives assist in understanding and making meaning from the story or stories. Interactions between storyteller and listener creates the ability to *think with* the story. It is this social aspect that Smith and Sparkes (2011) highlight, stating a 'narrative is a form of social action and the act of narration is a social activity involving other participants who may provide storied responses to a story heard' (p. 39). According to Frank (2010, p. 14), narratives are 'resources' or 'templates' from which we can create or make sense of stories; he further states, 'a consistent distinction between narrative and story is difficult to attain in usage' (Frank, 2010, p. 14). Caddick (2018) supports this idea of story/narrative 'overlap', stating 'it is not possible to refer to one without invoking the other' (p. 4). With that in mind, I, too, acknowledge that this current research will not achieve a complete separation of the terms, and sometimes will use them interchangeably.

Narratives are rich, meaningful, and can be multi-layered and are useful for analysis. Due to the richness and depth that can be achieved within narrative research, there is an increased use within different academic disciplines (Bold, 2012). Within psychology, Erikson investigated identity and veterans (1968). Put simply, Erikson's work focused on the need for these veterans to have a coherent and consistent sense of self and identity throughout their life, especially after serving in World War II. He found this identity process could be ongoing instead of a fixed occurrence, which was previously thought to happen only during adolescence (Erikson, 1968). McAdams expanded on this concept to include the socio-cultural dimensions of one's life (Kroger, 2015). This approach is about the integration of all the aspects of one's life, making the narrative malleable when something happens to make a person reflect upon their story and who they are as they transition from youth into adulthood. It is this continual formation of—or addition to—one's identity that can happen in a setting such as basic training, or many years later, when one is injured and undergoing rehabilitation.

People continually reconstruct and reintegrate his or her self and their story to achieve unity across a lifespan (McAdams, 1985, Frank, 1995; McAdams, 2011). This ability to reshape the narration is done via three 'identity strands': social actor, motivated agent, and autobiographical actor (McAdams & Zapata-Gietl, 2015). The first 'strand', the social actor, is wherein one realises they have roles to perform for an audience. McAdams' and Zapata-Gietl's second strand, the 'motivated agent', has beliefs, goals, and desires that shape them; the third 'strand', the 'autobiographical actor', makes sense of the past, present, and future of their life (2015). The concept of a performing social actor is related to Mead's and Goffman's sociological work. For Mead, there is always the 'other'—a person always has an audience or someone watching (1934, p. 230). Goffman (1959) explains that life interactions are much like a stage on which people enact different roles for different audiences through a 'performance'. The combination of these—an 'autobiographical actor', the 'other', and a 'performance'—assisted my understanding of an intersubjective dynamics at work during this research.

Questions of ontology and epistemology

My research is located within an intersubjective, interpretivist perspective founded upon ontological relativism and epistemological constructivism. According to Smith and Sparkes (2008, p. 13), the interpretivist perspective is 'a commitment to both the proposition that there is no real world independent of our knowledge of it (ontological relativism) *and* an epistemological constructivism'. Further, this perspective does not claim 'procedural objectivity', rather that 'gaining access to a real world, "real" selves or "real" experiences independent of our fallible knowledge of it is considered a chimera. Similarly, lifting the veil of the social and claiming discovery of some sort of self inside the mind, or lived experience beneath in correspondence terms is viewed as untenable' (Smith & Sparkes, 2008, p. 13).

Sparkes and Smith (2014, p. 11) state ontological relativism is a 'social reality as humanly constructed and shaped in ways that make it fluid and multifaceted. Multiple, subjective realities

exist in the form of mental constructions. In this perspective it *is* accepted that physical things exist out there independent of ourselves (emphasis in original).’ As such, ‘knowledge is socially constructed’ and ‘we can never know if or when we have accurately depicted the real world as it really is (epistemological constructivism)’ (Smith & Sparkes, 2008, p. 9-10). Knowledge does not exist ‘out there’ to be discovered but is inseparable from—and created by—the ‘knower and the known’ in a ‘subject-subject relationship’ (Sparkes & Smith, 2014, p. 13). Sparkes & Smith (2014) further explain that ‘values always mediate and shape what is understood. The knower and the known are inter-dependent and fused together in such a way that the “findings” are the creation of a process of interaction between the two’ (p. 13). It is this ‘inter-dependent’, ‘socially constructed’ knowledge that informs and guides the current qualitative research and analysis about embodiment, disability, and identity.

Narrative Inquiry

The intent of this research was to use narrative inquiry, via semi-structured interviews, to gain knowledge of how someone renegotiates identity and embodiment following a traumatic physical event. The objective is to assess the narration and meaning-making injured persons apply to their lives after a critical life event. Narrative inquiry, or life history research (through the telling of personal stories), is a method of achieving rich, complex, and in-depth knowledge through personal interviews. Interviews give space to the participant to tell the story of their life: how they understand it and how they give it meaning. Narrative inquiry allows people to use their own voice for the creation of their stories and the telling of experiences (Squire, et al., 2015). Certain life occurrences are sometimes difficult to verbalise but telling others about the event through a story is a way to achieve speaking about it. Hartley (2013) states, ‘[R]emembering and narrating the past is not a static process, but rather an active one through which people incorporate, take account of, or negate the past’ (p. 181). Stories can help explain how major life events (Squire, et al., 2015) or ‘biographical disruptions’ (Bury, 1982) are woven into one’s life narrative. Becoming disabled due

to an injury is a 'life rupture' (Bury, 2001, p. 264) and how one incorporates that event into his or her life narrative can be dependent on support systems, extent of injury, and mindset. If a person becomes disabled later in his or her life, they must acquire a new way of living; from basic bodily needs, such as bathing, eating, or going to the bathroom, new modes of movement must be addressed and learned (Smith, 2013). Whilst Bauman's work indicates that everyone will have a body that inevitably fails (1992) and McRuer (2006) asserts that, as one ages, they await 'the disability yet to come' (p. 200), this research sought to collect the stories of negotiating a disabled body, which came early and traumatically in life due to their military service.

The person with illness or injury can become simply a body to be written or talked about without the inclusion of telling his or her own story. Charon (2006, p. 3) argues that those experiencing illness are passed through a medical system by their practitioners as such:

Instead of being accompanied through the uncertainties and indignities of illness by a trusted guide who knows them, patients find that they are referred from one specialist and one procedure to another, perhaps receiving technically adequate care but being abandoned with the consequences and the dread of illness.

Unlike medical narratives that are used by professionals and practitioners using medical terminology to talk about an ill (or, as I suggest, an injured) body, personal narratives explain the experiences, thoughts, pain, feelings, and emotions that occur during—and after—the illness or injury. The ill or injured person's perception of what has happened to them can be expressed through storytelling.

Language is also important when using narrative inquiry as a research method, as it locates where the narrative sits amongst all else in the storyteller's life. The narrative is a 'window into a particular socio-historic moment and a way of understanding that moment's meaning for the narrator' (Squire, 2015, p. 84). This situating of a story allows the researcher to place it within the proper context of the time and place it happened, as well as what that means to the storyteller.

The type of language used in my participants' stories had some military jargon and a few medical terms but was mostly very listener friendly. In other words, the stories were easy for me to understand within the narrator's language even though they occasionally included words I did not typically use. Whenever I did not understand, I either asked for clarification or the participant could see by my facial reaction that I did not comprehend. They would stop and explain, then continue with their narration.

Narrative inquiry also allows the space for dialogue detailing the injured person's feelings and experiences in ways that a survey or questionnaire cannot. The research within this thesis investigated the gaps that exist in the current literature about younger veterans, disability, and their life experiences after a traumatic physical injury, which can cause them to lose part(s) of themselves, both literally and figuratively. Investigating how their lives were before the injury and comparing it to their current daily life experiences post-injury provide insights into how the injured service member approached rehabilitation, recovery, and their transitioning out of the military. The current investigation further illuminates how they handle everyday embodied life occurrences, such as household chores, driving, or moving into and through public spaces (for example, buildings or pubs).

Illness narratives and meaning-making

Previous literature surrounding traumatic injury was medically based and did not always give a qualitative, in-depth, personal story about this issue.¹³ Narrative discourse, according to Sacks (1984), should be concerned about the 'human', which is 'first and last *active*—a subject, not an object' of the illness experience (p. 177). There is some literature surrounding 'the need to distinguish disease, as phenomena seen from the practitioner's perspective (from the outside),

¹³ See, for example, Frank's account of a man whose surgeon had written an entire article about the man's reconstructive facial surgery, inclusive of pictures, without ever once mentioning the man himself (Frank, 1995, pp. 15-16).

from illness, as phenomena seen from the perspective of the sufferer', as Garro and Mattingly assert (2000, p. 9). Lived, embodied traumatic experiences transform what was a whole body into a person with amputations or other physical injuries, which forever alters the bodies and senses of those wounded. There are many ways of coping, adapting, and adjusting, especially with prosthesis use (Murray C. D., 2009), which I investigated through narratives.

Narration of the life changes surrounding injury, disability, or illness diagnosis enables the teller to make sense of—and share—the experience (Bold, 2012). Understanding how injured persons must re-learn through their senses and their body in order to live a different life is a vital point of research, which has ramifications beyond the injured person or their family to many types of communities such as researchers, medical practitioners, and policymakers. In order to understand the transition of being able-bodied to being injured, disabled, or chronically ill, narrative inquiry can be used. Drawing on Arthur Frank's (1995) analysis of 'illness narratives' and meaning-making, lives after unexpected injury may be better understood through story-telling.

Frank explains that throughout history, illness was understood by the telling of stories by the ill person. Over time, the words of the ill were replaced by medical terminology and the story's authority then rested with physicians. Frank refers to this timeframe as the 'modern period' wherein the story that 'trumps all others is...the medical narrative' (1995, p. 5). Physicians, who could diagnose and treat the illness, used the medical articulation of embodied experiences, such as illness or pain. These are the patient histories that were then told and considered valid (Bourke, 2014; Frank, 1995). Then there was a shift back to ill people telling their own stories in their own words; this reversal is what Frank calls the 'postmodern experience' (1995, p. 6). In Frank's postmodern story, the person experiencing the illness asserts one's agency, 'refusing narrative surrender', by using one's own voice and words instead of the externally imposed medical version (1995, pp. 16-18).

In *The Wounded Storyteller*, Frank (1995) discusses how the diagnosis of a chronic (and sometimes fatal) illness changes a person's life narrative. He classifies three types of narratives: restitution, chaos, and quest. For the restitution narrative, the ill person seeks to return to as close as possible to normal (how they were prior to the illness). Within the chaos narrative, the ill person doesn't see a path forward but also realises they cannot return to how they were prior to diagnosis. Many times, the chaos narrative is never fully understood as the person does not verbally expound on their experience or is unable to do so. The quest narrative is when the person, precisely because of the illness or injury, decides to see it as a challenge and be better than before. It is not just a person's verbal stories but also the experiences of their wounded bodies; bodies 'speak' through gestures, glances, emotions, pain, and other embodied expressions. The body is a subjective site that can encounter a disruption, altering perceptions and experiences that need telling and made public (Bury, 1982; Csordas, 1990; Bury, 2001; Charon, 2006). Frank argues that capturing the various experiences of the wounded, ill body through different types of narration is beneficial for both the storyteller and those who are listening.

Research design: Interviewing and criteria

Interviewing as chosen method

Having emerged from the political science world, I had learnt data was to be gathered using statistical, reproducible, quantitative methods. Whilst understanding that this positivist approach has its benefits focussed on relating cause and effect as well as its predictive powers, quantitative methods seemed to lack the inclusion of particularly interesting, in-depth, and insightful data about the people it researched. The interest for qualitative research, according to Pinnegar and Daynes, lies 'not in prediction and control but in understanding' (2012, p. 4). I wanted to focus on—and understand—people's lives, so using qualitative, personal data collection within research about major life changes and subsequent daily experiences appeared the obvious choice for this research.

With this perspective, I chose the qualitative method of in-depth, semi-structured interviews due to their ability to gather rich data that is impossible to generate on a survey or questionnaire. I also wanted to be present with my participants in face-to-face interviews, which allowed a more dynamic approach to my research. I used Langellier and Peterson's (2004) concept of 'performative narrative', where it 'requires bodily participation: hearing and voicing, gesturing, seeing and being seen, feeling and being touched by the story-telling' and is 'possible by bodily participation, including the researcher's body' (pp. 7-8). Further, they make the point that the person telling the story is '[e]mbodied before an audience simultaneously as both a narrator and a character, both a speaking subject and a subject of discourse' (Langellier & Peterson, 2004, p. 9). Face-to-face interviewing allows for immediate accessibility for follow up queries, clarifications, and other instances of dialogue that are not possible with other types of narratives that are written, such as autobiographies or diaries. According to Deschaux-Beaume (2013, p. 111), 'The qualitative interview is not only a way of gathering data but also full of social interaction between the researcher and the interviewee'. It was this social interaction with my participants that enriches this thesis and its research.

Further evidence supports not using a written research method (a written diary, journals, ethnographic accounts, academic articles, or books) due to possible problems mentioned hereafter. A diary or journal might allow more time to write out a participant's thoughts; however, it also could be put aside if the participant is too busy or has other reasons for non-completion. Autobiographical books can have their own issues, as the book might be written by a ghost writer, or if the book is written by the injured veteran, it will be edited by the publisher. Academic articles can be illuminating, especially if written by a former service member but the length of the articles' limits or the reviewers' suggestions impact what information is finally accepted for printing. Due to the reiterative process of writing books or academic articles, the narrative (data) might lack the rawness of being in the moment of storytelling that I wanted this research to capture. Being in the same time and place during the interview gave me the opportunity of conducting the research in a

way that would be most convenient for the participant and would be considered complete once the interview concluded. My participants found this 'one and done' approach to be favourable for two reasons: 1) because it was not overly labourious (as I travelled to wherever they lived in England), it increased their willingness to participate and 2) it made it simpler to fit into their (sometimes quite busy) schedules. At the conclusion of each interview, I verified that either of us could contact the other if we had follow-up queries or comments. I assured participants that they could always contact me if they had concerns, follow-up questions, desired the addition of anything further to their narrative account, or just wanted to 'check-in' about the research process.

My choice of interviewing ex-forces (also known as ex-Service personnel or veterans) was due to their being formally discharged from the military institution. I wanted to have participants speak as openly about their injury and military experiences as they desired. Difficulties with speaking freely about one's experiences lessen after departure from the armed forces, as the participant could choose whether to remain identifiable or request anonymity. This option will be further discussed in the 'Ethics Section' below.

Whilst the military interviewee is still serving, a researcher is able to 'quote the institution and service where the interviewee works but not his name and function' (Deschaux-Beaume, 2013, p. 141). I found this to be true when working with currently serving officers about my research and recruitment. Whilst supportive of my research and its aims, they were representatives of the military and spoke as such. In other words, they were helpful to further my understanding particular pieces of the military process or institution, but not always able to speak directly—'for the record'—to any concerns about my participants' injuries (or their futures) that the officers may have personally held.

Interview Schedule

Due to the interdisciplinary nature of my research, I composed an interview schedule, or questionnaire, consisting of a few basic demographic questions, followed by open-ended queries

(see Appendix A). Beginning with the demographics allowed an easy transition into the interview proper by having simple, easy to answer questions and acclimatising the participant to being recorded and interviewed. The interview schedule was structured so as to address participants' daily experiences prior to the injury with the majority of open-ended queries about their experiences following the traumatic injury. Questions incorporated injury, embodiment, memory, medicalisation, surgeries, rehabilitation, resettlement, friendships, pain, technology, and prosthetics (where appropriate). I felt it was important to ask questions about the participant's military job, the type of injury incurred, and how that impacted his or her use of their body, specifically about pain, prosthetics, and bodily abilities. I focussed on rehabilitation—therapy, daily routines, and being amongst fellow military personnel. Questions about experiences of leaving the military, what types of friendships they currently had, and what activities they did to fill their time were asked. I also enquired about what they thought people's perception of them was after their injury.

Most of the questions I prepared were from reading medical literature and noticing the lack of the personal experience from point of injury through rehabilitation. Critical disability studies literature (inter alia Oliver (1996), Murray (2009); McRuer (2006); Garland-Thomson (2002); Garland-Thomson (1997); Sacks (1984)) informed some of my questions surrounding embodiment as well as societal interactions. As I was preparing the questionnaire, I sent it to a British Army veteran for assistance with terminology and clarity. I did not revise the interview schedule after testing it in the field. After the first interview, I decided to begin asking the participant about his or her childhood and family during the 'demographics' section; this decision was made with the aim of having more recorded dialogue before turning to questions about their injury. I found this to be helpful for building rapport and also give them the opportunity to tell me why they joined the military; oftentimes they had a family member who also served in the armed forces or they felt it was a path to a 'better' socioeconomic life. (One participant was very explicit in telling me that he joined the military in order to save himself from a life of crime.)

Criteria

The population I recruited are ex-service personnel (veterans), specifically due to the time involved in getting approval to research currently serving personnel and their ability to speak 'off the record'. The Ministry of Defence Ethics Committee approval process can be quite long and, too, I was interested in those who had exited the military due to their injuries. Therefore, interviewing currently serving personnel was not appropriate. I wanted to focus on those having served in more recent, post-2000 conflicts, such as Operation TELIC in Iraq and Operation HERRICK in Afghanistan, so set the ages for recruitment from eighteen to fifty years (18-50 years).¹⁴ The aim for this age group was to research a population that may have been quite young when their injury occurred and have many decades of life before them. All participants experienced traumatic physical injuries, such as burns, limb loss (amputation), hearing loss, loss of sight, a spinal cord injury, or a combination of those injuries (poly-trauma). My goal was to interview enough participants to find themes across their narratives, reaching a saturation point where few or no new themes would emerge from additional participants. Similar studies using qualitative research have interviewed between fifteen (15) and thirty (30) participants (Mason, 2010; Lewis, DiGiacomo, Currow, & Davidson, 2014; Hollander & Gill, 2014).

Whilst the study was not aimed at researching one gender, all participants were male. Because I wanted to research life stories surrounding bodily injury, I excluded veterans who had not experienced a physical injury. There were a few people who contacted me about researching post-traumatic stress. I let them know that, whilst I was grateful for their interest in assisting with the project, it was outside the remit of this particular sociological study. Anyone who had post-traumatic stress disorder (PTSD) gave the information voluntarily as part of their narrative but it was not a topic that my study explicitly addressed.

¹⁴ One participant was over 50 years of age but had been injured relatively young, which impacted his physical abilities during his remaining years in military service.

Recruitment: Cultural immersion and recruitment process

My recruitment consisted of several approaches, from traditional pamphlet advertisements, face-to-face meetings, on-site visits, social media advertising, presentations, and direct contact via emails and phone calls. I found the recruitment process to require much perseverance, adaptivity, and resilience on my part. I created a website, which addressed my research, my university affiliation (University of Portsmouth), and gave a short introduction of myself.¹⁵ I initially spent many months working with a large military charity organisation in the United Kingdom, doing site visits to two (2) of their centres, and submitting a research application in order for the charity to advertise my project. Upon the organisation's suggestion, I contacted the Project Manager of the **Armed Services Trauma Rehabilitation Outcome Study** (also known by its acronym, ADVANCE), and she invited me to visit the rehabilitation centre.¹⁶ Whilst there, I was told the ADVANCE study would not be doing in-depth qualitative research. Unfortunately, my research application mentioned above was ultimately turned down in a slightly paternalistic way—the charity made the decision for their beneficiaries instead of allowing the beneficiaries to decide for themselves if they would like to participate in my project. I visited other military charities who were vocally supportive of my research. The time spent with each person, however, usually ended without any explicit assistance, but rather with my meeting yet another person the 'gatekeeper' thought would be interested in my work.¹⁷

Since the military charities were helpful only inasmuch as vocal support or offers of advertising, I decided to cease the 'gatekeeper' approach and switch my focus from in-person visits to technology: online advertisements on the Army Rumour Website and the Navy Net website. After receiving approval from the site moderators, a few people demonstrated interest and two

¹⁵ <https://lifeafterinjurysite.wordpress.com>

¹⁶ More can be found here: <https://www.imperial.ac.uk/blast-injury/research/networks/advance-study/>

¹⁷ I visited the Army Benevolent Fund, a Royal British Legion Centre, and a British Limbless Ex-Service Members Association (BLESMA) representative.

interviews came about from this approach. I emailed and called various charities and local news outlets, such as *The News* and the *Navy News*. Further, I attended various military days in the community physically distributing my advertisement and in order to meet anyone who might be interested in my research. I also visited the local prosthetics centre, the Portsmouth Enablement Services Centre, located at St Mary's Hospital and met with consultants in order to gain a better understanding of the process of prosthetics. One of the consultants spent more than two hours with me, demonstrating the process and showing me the different rooms in which prosthetics are made, moulded, and tested. Whilst there, a British Army veteran gave me his insights into the military, war wounds, medical discharge, and amputation. I was fortunate that the consultant and the veteran explained the process, necessities, technology, and benefits of prosthetics.

Since I am also interested in how injured bodies deal with ageing, I submitted a poster on my research to the University of Portsmouth Ageing Network. Whilst presenting my poster I met a former Royal Air Force veteran who shared military charity organisations' information. I also met a representative from Dementia UK, who connected me with the Royal British Legion Admirals Nurse, whom I met with in Portsmouth. Another opportunity arose at the Portsmouth Enablement Centre, where one of the consultants encouraged me to present my research at the British Association of Prosthetists and Orthotists Conference. During the conference, I met Dave, who is a former British Army Officer, double amputee, and a participant of this research.

Another participant, Mark, recommended visiting the Hasler Company, HMS Drake in Plymouth, as it is an active-duty transitional unit that serves Wounded, Injured, and Sick (WIS) service personnel. Permission was granted for me to visit this Naval Base and I was given a tour of the facilities, inclusive of the various buildings where the WIS personnel have rehabilitation and where they are housed during their stay. I also met several WIS whilst there. Additionally, and in order to understand the basic training process (specifically for the Royal Marines), I contacted the Commando Training Centre Royal Marines at Lympstone. Fortunately, permission was granted for

my visitation to this second military site. The time spent with the Lieutenant Colonel at Lympstone was very helpful in understanding what type of physical and mental obstacles the Royal Marines face during their initial basic training as well as the motivation to continue onward despite physical inconveniences and limitations.

Direct recruitment

As more time passed without accruing interviews, I again changed my recruitment tactics. I sent a few direct emails, which, in the end, is what produced interviews. An email to the local military charity in Portsmouth resulted in a meeting with the Chief Executive Officer, followed quickly by his recommending me to possible participants—two of which agreed immediately. I sent an email directly to an injured veteran (single amputee) through his personal website; he responded, and I interviewed him shortly thereafter. I also sent an email to a double amputee, whom I had met at a presentation (mentioned above). He agreed to participate. Another ex-Service member was directly messaged via Twitter. Other participants were reached through snowball sampling, which is defined by the acquisition of new participants through previous participants, called ‘waves’ (Heckathorn, 2011) or ‘links’ (Atkinson & Flint, 2001; Spreen, 1992). The dynamic is such that one person’s participation begets one more participant, who begets another, and onward, creating an incremental, ‘snowball’ effect. Used as an informal methodological approach, Atkinson and Flint (2001) maintain that snowball sampling has ‘practical advantages’ in ‘explorative, qualitative, descriptive’ research especially when the population is small or ‘where some degree of trust is required to initiate contact.’ One of the benefits to snowball sampling is that it allows for ‘dynamic moments where unique social knowledge of an interactional quality can be fruitfully generated’ (Noy, 2008, p. 328). This methodological approach, however, is not without shortcomings due to possible bias, findings not being generalisable (because the participants are not random), and there can be an ‘over emphasis’ of people from a particular network (or group) being studied (Heckathorn, 2011; Atkinson & Flint, 2001). Six interviews were achieved through

snowball sampling; this was because I received approval by one of their friends, who then recommended me. Therefore, new participants agreed to speak with me due to the endorsement. Lastly, I met a veteran at another military-related function and, after speaking for a few minutes, he volunteered to participate.¹⁸ These direct recruitment approaches were the most fruitful and, despite the original paternalistic protectiveness I found with the large military organisation, the men I interviewed were quite willing to talk about their experiences, especially once they knew the information will be published and presented. Several participants stated they wanted to ‘help someone else’ by telling their story of injury and recovery and so were reassured that the findings of this research will be publicly available.

The settings where the interviews took place further highlighted the different types of dynamics that occurred between my participants and me. The lines of researcher/researched and masculine/feminine blurred within these spaces, adding, as Atherton (2016, p. 309) states, ‘further depth to the narratives’. For Atherton’s fieldwork on interviewing veterans and military masculinities, he noticed that when the participant was speaking in a domestic space, there was a greater chance Atherton’s participant would be more emotional, more comfortable, or disclose more information (2016). For my research, more than half of the interviews took place within the participants’ homes. It was my experience that this personal space for interviewing allowed the participant to be more open and interactive. For example, several participants acted as caretakers of me—ensuring I was comfortable, that the set-up and space for recording would work, and that I had coffee, tea, and food. Others used the location as a way of displaying their multiple prosthetics and describing what functions the artificial limbs served (e.g., a ‘running’ leg versus an extra ‘walking’ leg). In fact, some even allowed me to view their scars. In this way, my participants allowed me into their private homes, welcoming me, and yet also wanting me to know more than I

¹⁸ This military-related function is entitled ‘Military Human: Understanding Military Culture & Transition’, which is a training course hosted by York University. See <https://www.yorksj.ac.uk/courses/professional-and-short-courses/military-human/>

was asking about in the interview by displaying the physical reality that exists upon and within their body (the scarring) or through their bodies (types of prosthetics).

This inclusive form of bonding in the home over food and stories might seem odd or overly familiar. I think, however, the inclusivity has to do with my being ‘approved of’ and referred to them by someone whom they trusted. Too, the understanding was that I was credible; therefore, the participants did not hold back information during their time with me and so were very engaging. Additionally, the inclusive behaviour indicated a form of acceptance, as was exemplified by one interview that began in a public park and ended with tea in the participant’s home with his family.

For the rest of my participants, our rapport was almost as instantaneous. It helped to have spoken with them prior to meeting in person, but I found that almost all of them had behaviours and speaking patterns similar to a ‘big brother’. In other words, the exchanges included easy bantering, showing off, being brutally honest, jokes, and, seemingly most important, expecting the tenacity to dialogue with them and ‘keep pace’. In many ways, this type of interaction felt as if we were studying each other. I studied them because of their injuries, and they studied me because I was such a peculiarity from their usual daily experiences (more about this in the Positionality section below).

At the end of recruitment, I had a sample of twelve (12) participants, presented in the table below. The table also lists the year and type of injury, the country in which they were injured, and the branch of the Armed Forces in which they served: *(Table on the following page)*

Participants	Year Injured	Injury type	Country where Injured	Cause of injury	Branch of Military
J.D.**	1995	Traumatic Brain Injury; broken legs; broken ankles; permanent nerve damage in feet	United Kingdom	Car accident	British Army
A.D.**	2003	Traumatic Brain Injury; Epilepsy; Tinnitus	Iraq	Bomb/explosion	Royal Air Force
Colin	2006	Spinal Cord Injury	United Kingdom	Basic Training (and Sudden Pull)	Royal Air Force
Mark	2007	Amputations: arm and bilateral above knee	Afghanistan	IED	Royal Marines
Pav	2008	Spinal Cord Injury, Tinnitus; Hearing loss	Afghanistan	Suicide Bomber	British Army
Andy	2009	Amputation (elective): single below knee	Afghanistan	IED	Royal Marines
Ken	2009	Amputations: bilateral above knee; Internal injuries; loss of thumbs and several fingers	Afghanistan	Bomb/IED	British Army
Jon	2010	Amputations: arm and bilateral above knee; nerve damage in remaining arm	Afghanistan	IED	Royal Marines
Paul	2011	Amputation (elective): single below knee; broken neck; left frontal lobe destroyed; blind in one eye; deaf in one ear	Afghanistan	IED	Royal Marines
Dave	2011	Amputations: bilateral (through-knee and above knee)	Afghanistan	IED	British Army
Lee	2014	Amputation: single below knee	United Kingdom	Roadside accident	Royal Marines
J.P.**	2014	Burns; severe leg damage; extensive pain daily; will need amputation in future	Afghanistan	IED	Royal Marines

Table 4.1: Participant Injury Information (** indicates initials used for partial anonymity)

Data collection, storage, and analysis

All data was audio-recorded. I then transcribed the data from the twelve (12) participant interviews in full detail using an online transcription site. The transcriptions were analysed based on the questions asked and the information the participants gave. Color-coding was used to assist in analysing the data and generating themes. Analysis of the participant data was an iterative process, using thematic analysis. This method ensures the researcher is familiar with the data and can code for themes; first for possible themes within and across the data, and then naming and

classifying those themes (Braun & Clarke, 2006). Braun and Clarke (2006) highlight an advantage to using thematic analysis because it will give greater insight into participant data and illuminate homogenous or heterogenous information.

In more recent work, Braun and Clarke (2019) define a more nuanced analysis, the reflexive thematic analysis, which is the recursive process I used for this current research. This process, according to Braun and Clarke (2019), consists of the following phases: (1) familiarisation with the data (reading and re-reading the data); (2) coding ('generating labels or codes about important features of the data'); (3) generating initial themes (Identifying broader patterns of meaning); (4) reviewing themes (ensuring the themes 'tell a convincing story of the data (..) that answers the research question'); (5) defining and naming themes (naming themes and performing 'detailed analysis of each theme'); and (6) writing up—the 'weaving together the analytic narrative and data extracts'. This inductive method allowed for deep immersion within the data so that the themes become apparent as I engaged with and analysed my data.

During analysis, new themes emerged that I was not expecting, such as forming new friendships in rehabilitation. I originally approached the research thinking the data would fit onto the framework of Arthur Frank mentioned above (narratives would align with restitution, chaos, or quest) but the participants' stories troubled this preconception. Narrative themes were more complex than Frank's three concepts of restitution, chaos, or quest. The data did not fit neatly into one of these three categories but sometimes conflicted or complicated an 'easy' or obvious definition. There were overarching themes from the data, such as adapting to a post-injury body, attempts to find agency, and post-injury autonomy. All of the themes from the data will be discussed in the following empirical chapters.

Ethics and risk assessment

Ethics process

In order to perform the interviews, I worked with the University Human Resource office to acquire clearance of the Disclosure and Barring Service (DBS) check, which is the United Kingdom's criminal background check. Additionally, I went through the university ethics process, with a submission of the research protocol, participant documents, and the proper risk assessment form. As part of the research ethics and interview preparation, I knew that those who agreed to speak with me would be sharing very traumatic experiences; the extent to which they did was ultimately up to them. Some spoke of their incident for quite a long time whilst others were very concise and rather limited in their responses. Following the guidelines from both British Sociological Association's Code of Ethics (2017) and the University of Portsmouth research ethics protocol (University of Portsmouth, n.d.), I ensured that a participant had full access to the topics we would cover as well as giving them the opportunity to speak with me (via Skype or FaceTime) prior to meeting for a face-to-face interview. This engagement allowed the participant to read the questions we would cover and also to ask me direct questions.¹⁹ I also emailed the participants the Invitation Letter (Appendix B) and the Information Sheet (Appendix C). This approach was also helpful for arranging for a day and time for the interview, as it could be quickly decided verbally instead of emailing back and forth. The participants were also told they could withdraw anytime, without question, prior to the writing of the thesis.

Concerning the research participants, anticipated risks were that the discussion of injury could cause psychological distress. Discussion of sensitive topics might be raised, but I was respectful of participants' privacy and feelings in regard to their comfort level and desire to answer/skip questions. Since they were volunteering to participate, it was assumed they would be prepared to discuss their injury and life experiences. As a built-in protective measure during the

¹⁹ Almost all of the participants were curious about an American studying United Kingdom injured ex-service personnel when there were so many more in the United States.

interview, the participant could choose to either not answer any discomforting question(s) or end the interview at any time of their choosing.

Whilst none skipped questions or ended the interview, there were a few moments when it was clear to me that the participant was in an explicitly emotional 'space' and to dwell there would not be beneficial to the participant. One participant in particular was not in the habit of telling the story of what had happened to him, so, even whilst many years have passed since his injury, the act of talking about the injury and the subsequent medical discharge experience was clearly emotional for him. When this occurred, I would pause and refocus the interview, going back to expand on a previous question or moving on to a different line of questions. Unlike Atherton, who mentions his own 'feelings of discomfort', 'anxiety', and 'helplessness' whilst interviewing injured or disabled men (2016, p. 313), I did not experience distress or uneasiness in speaking with my participants about their experiences. I do recall feeling quite empathetic when they spoke about their time in hospital, specifically waking up and seeing their injuries or the pain they felt; however, I was not uncomfortable or anxious about the discussions. In part, my comfort with the subject was 'tried and tested' through my pre-PhD experiences whilst volunteering for the 2015 US Department of Defense Warrior Games,²⁰ which, much like the UK Invictus Games,²¹ uses sport for physically and mentally engaging wounded, ill, and injured service personnel and veterans from around the world. I found the time I spent volunteering and interacting at the Games to be helpful in my resolve in addressing the topics of injured service personnel more in-depth through my current research. Further, some of the medical literature had graphic content, which I read in preparation for my research. These two experiences gave me a sense of mental preparedness that I know I would not have had without volunteering or seeing the visual representations of explosion-related injuries.

²⁰ See the Department of Defense archived site: https://dod.defense.gov/News/Special-Reports/0615_warriorgames/

²¹ See the Invictus Foundation website: <https://invictusgamesfoundation.org>

Another approach of transparency for the semi-structured interview was that participants were given the questionnaire prior to our interview so they are aware of the questions to be asked. This method better prepared the participant to tell me if they'd like to skip any discomforting questions. Since participants were self-selecting and agreeing to the research with the information sheet, consent form (Appendix H), and questionnaire prior to the interview, it was assumed they were confident in their ability to be interviewed.²² They were reminded at the beginning of the interview that they could stop the interview at any time and withdraw if they chose. As another protective measure, anyone who mentioned harm to self or others would be referred to appropriate agencies for care (more information on this in Risk Assessment below).

In accordance to the British Sociological Association Code of Research Ethics (2017), informed consent was obtained from the participant before the start of an interview using a form that explained the research, its intended goals, and how it will be used. Prior to interviews, I emailed participant information letter and interview questionnaire to the participant. At the beginning of any interviews undertaken, the participant was verbally taken through the informed consent form, which was then signed by the researcher and the participant. Confidentiality is in accordance to the Data Protection Act of 1998. All of the patient data collected is kept confidential through password-protected computer/laptop, use of encryption for documents, and any physical documents kept in locked filing cabinets. Access is only for the investigators on record. If the participant desired, his or her data would be anonymised to protect his or her identity. My participants could choose from the following consent form options: fully identified, partially identified, anonymous (researcher to choose my pseudonym), or anonymous (participant to choose pseudonym). These options were specifically chosen to give the participants full ownership of how they wanted to be identified within this research project. The ethical importance of anonymity decisions cannot be understated. For example, Grinyer's narrative research with families who had

²² These documents are provided in the Appendices.

a child diagnosed with cancer challenges the previous legal precedents set for anonymity, stating '[T]he issue of identity/anonymity is more complex and less predictable than it might at first appear' (2002, p. x). Many of Grinyer's participants were distressed with the use of pseudonyms in the presentation of the research, as they felt they had 'lost ownership' and 'betrayed' their child's memory, requesting to always be identified from then onward. Grinyer found that the traditional assumptions and requirements for not using participants' names created the awareness that participants should be entitled to choose exactly how their personal experiences and stories are told (2002). In my research, several participants verbally stated this precise issue—that they desired to be identified because it was their story. However, three (3) participants requested to be partially identified, which I had explained would be their first name and last initial or initials only. They agreed to this approach. I later decided to use initials due to the fact that one of the participants expressed concern about having a unique background, which would have increased the chance of identification. For consistency, since I had two (2) other participants who also wanted partial identification, they, too, would be referred to by their initials. Whilst the three participants were not overly concerned enough to request complete anonymity, my approach to this request was to use initials. If any participants had indicated they wanted complete anonymity, I would have made all participants anonymous so that any research findings (my thesis, papers, and/or presentations) would only discuss results but not be traceable/identifiable to participants. Since this wish for complete anonymity did not occur, I have chosen to use first names for those participants who desired identification and initials for the participants who requested partial identification.

Risk assessment

During the university's ethics process, a few concerns were raised both for the participant and the researcher. It was decided that a fieldwork protocol would be established for the physical safety of the researcher, and for the well-being of the participants and the researcher due to

possible psychological trauma (Craig, Corden, & Thornton, 2000). I attended the university's 'Risk Assessment Training' course prior to my project's Ethics Committee application. Due to the possibility of in-home interviews, a risk assessment and plan were created for the researcher in cooperation with the first and second supervisors. The risk assessment form can be found in the appendices (Appendix D). This protocol was put into place for the safety of the researcher. In the instance where the interview took place in a participant's home, the researcher ensured a third party (the first supervisor) was aware of the location, date, and time of interview as well as a verification that the researcher was fine via text message when the interview was completed. Further, under the suggestion from the Doctor Edwards of the MoD research study mentioned above (the ADVANCE study), I enquired about post-interview counselling services at the university. This recommendation was due to the possibility of very explicit and unsettling information (about the physical experiences of injury) told to me during interviews, which I might have needed to discuss afterward.

I was constantly aware of the possibility for issues surrounding the mental health, well-being, and physical safety of the participant—or their loved ones—to arise. Since one cannot predict what others will say during an interview, it was possible that a participant may disclose something of a personal nature dealing with activities that could be illegal, such as using drugs or firearms. Also, if the participant had mentioned something harmful to self or others, such as suicide or domestic abuse. Had that happened, I would have allowed them to finish the interview and followed the university protocol for handling something that may have come up during an interview that I felt could be harmful. Knowing that I was not qualified to deal with such serious issues, I would ensure that my participant was contacted, and cared for, by a trained professional. After the interview, I would have immediately contacted the correct authority with the information to allow them to follow up appropriately. I would have also remained in contact with my participant to verify they were getting helpful advice and care. Despite their traumatic experiences, my participants did not have any of these issues arise during our time together.

Military research methods and positionality

Military research methods

The military as an organisation or institution has been researched quite well through either the partnership of academia and the military or through the emergence of critical military studies (Rech, Jenkins, Williams, & Woodward, 2016). Rech et al. (2016) assert that this military research is traditionally quantitative in its methodology, creating the increased need for qualitative measures and methods. Additionally, because most of the previous research on or about the military, militarism, or militarisation is predicated upon quantitative data, 'there is a distinct lack' of engagement with 'subjectivities, experiences and life-worlds' (Rech, Jenkins, Williams, & Woodward, 2016, p. 29). This research will address and inform those issues, specifically around injury, medical discharge, and post-military life.

Qualitative military research is not without its problems. Investigating the people within the military institution can create an insider/outsider dichotomy for those attempting research about the experiences of a military population (Hockey, 2016; Walker, 2016). With Hockey's research on the British Army infantry, he was an 'insider' because he was in the military when he was younger, so was familiar with the routines and military vernacular. 'Insider-ness' for Walker's research on British Army service leavers was vis-a-vis his recent departure from an Army career. Both of these researchers, however, were technically 'outsiders' whilst doing their fieldwork as their 'insider' status was placed in their respective pasts.

Further, access is an issue with regard to 'gatekeepers' and the military population needed for a research project. Investigating the active duty population or their family members requires the ethical approval of the Ministry of Defence (MoD), which can cost time and resources that, unlike researchers with access through what Jenkins et al. (2011) call the 'military-academic research nexus', an individual researcher may not have. This fact of needing MoD ethical approval

if I desired speaking with injured personnel (in rehabilitation, for example) heavily influenced my decision about a research population. I focussed my qualitative research on medically discharged personnel, who were capable of consenting on their own behalf because they were no longer in service. Additionally, I spoke with an American military sociologist prior to my decision about a PhD, and she was unequivocal about the difficulties of access and the US Department of Defense needing to approve any type of study (whether on currently serving personnel or on wounded veterans). Since I was interested in investigating those persons wounded whilst serving in Iraq or Afghanistan no matter which flag they saluted, I pursued the possibility of my research in the United Kingdom.

Other approaches to military research include descriptive ethnographic work detailing the researcher's experiences with United States veterans, who have injured bodies, and what the transition is like for them or their loved ones (Wool & Messinger, 2012; Wool, 2015; MacLeish, 2016). These accounts delve deeply into the bureaucracy that military service members (or veterans) must deal with whilst attempting to claim agency within this system whenever they can. At times their agency is juxtaposed by the lack thereof, creating the need for stoicism. These tensions are written about by the researchers above, as well as how—or if—the service member can deal with the tension.

Positionality

Upon reflection of my positionality as a researcher, of note for me was that I am an outsider for many reasons, such as nationality (American), being a civilian, and being a female. Interestingly, the fact that I have military members in my family and that I have researched military issues for over a decade appeared to give my status some credence. I contacted several 'gatekeepers', or persons who are in military charity organisations or the military and are usually the deciding factor if you gain access to participants. When contacting 'gatekeepers', they told me it helped them to know both of the aforementioned facts about my family and military research.

Although I viewed myself as an 'outsider', in many of the instances wherein I met a 'gatekeeper' or a participant, I noted that they were always welcoming and hospitable. Most of the interviews took place in the participants' homes where I was incorporated and included into mundane activities, such as the making of coffee. Several 'gatekeepers' wanted to share a meal with me. In three different site visits, I was taken to an Officers' Mess to dine. I was unsure if this was an attempt to impress me or to impress the other officers present—perhaps both. It was also quite obvious I was a newcomer to the space as I was not in a uniform, I was one of (if not the only) female in the room, and my American accent ensured anyone within hearing distance would recognise I was not from the United Kingdom.

Making a good first impression with a 'gatekeeper' seemed vital to progressing in the attempt to reach participants. A few 'gatekeepers' mentioned to me that they were impressed with my education (I had given a resume to many of them with the confidence that I had the education and experience to approach this military research). Some of my meetings resembled those found in 'Encounters with the Military' wherein one is 'physically going and interacting with people and doing fieldwork' even though I had yet to speak with a participant (Baker, Basham, Bulmer, Gray, & Hyde, 2016, p. 141). I considered my fieldwork to be at two levels: meetings with the 'gatekeepers' and interviewing the participants. For the 'gatekeepers', interacting was about impressing them or gaining their approval. It seemed that once they saw and spoke with me, they were more willing to reach out to their contacts and possible participants. This reaction is understandable, as I had one 'gatekeeper' tell me that it was his responsibility to decide if a researcher was 'mad or bad' prior to assisting them with their research. Whilst it felt slightly paternalistic, this phrase was explained such that the 'gatekeeper' has an obligation to ensure the research will be productive and not a nuisance to their beneficiaries. My pre-interview interactions with the participants was similar to the 'gatekeeper' approach because we usually chatted via Skype or FaceTime prior to meeting in person. It was implicit that they wanted to spend a few minutes speaking with me to see if they were comfortable with the idea of me asking them questions about

a personal life event. These calls were helpful for both of us (participant and researcher) prior to spending a couple of hours together for the interview.

Conclusion

In this chapter I discussed the type of research as well as its process. I presented the research questions and my chosen method of narrative inquiry. The concepts of stories and narratives are explained, followed by the ontological relativism and epistemological constructivism that underpins this research. An overview of illness and meaning-making for life stories followed. I then discussed the research design, interviewing, and criteria. The recruitment process was described, with a table presenting the participants' injury information. This table is followed by my data collection, storage, and analysis. The ethics surrounding my research was presented, inclusive of the risks to both researcher and participants. Finally, I addressed military research methods and my positionality.

Chapter 5: The Instant and its Aftermath: Injury and Rehabilitation Narratives

Introduction

This chapter discusses my participants' narratives about the injuries they suffered and the rehabilitation that followed. Whilst the majority (9) sustained their wounds on operational tours, three (3) others were injured whilst serving in the United Kingdom. All of the participants had life-altering injuries directly affecting their military careers. The length of time between injury and military discharge varies for an individual, but the focus within this chapter highlights what caused their injury, the military rehabilitation experience, and how the rehabilitation setting impacted them. 'The stories are uncomfortable', Frank states, 'and their uncomfortable quality is all the more reason they have to be told' (1995, p. 58). MacLeish describes the stories and conversations surrounding the reality of the bodily damage done in warfare is something never 'spoken of in polite company' (2013, p. 85). But, we need to hear the stories and so, as Charon succinctly states, 'We donate ourselves as meaning-making vessels to the [person] who tells us of his or her situation' (2006, p. 132). Therefore, I present the following stories of severe, life-altering injury as described to me by my participants.

Beginning with a short overview of how blast explosions affect the body, we will turn to the participants' narrations about their injury: the instant it happened and what they recall from that moment. I will first discuss injuries that occurred on deployments in the section, 'Battlefield Injuries', and then turn to those wounded in England in 'Homefront Injuries'. An overview of the medical care pathway that injured service members experience is then presented. The chapter will

then discuss the overarching theme of adapting to their changed body and the other themes that arose from participants' rehabilitation experiences: continuity, camaraderie, and a change of perspective. In the rehabilitation setting, participants found an environment that felt familiar, much like a continuation of their previous military life. Participants also acquired new friendships and they spoke about developing a new frame of reference concerning their injury.

Narratives of injury

Physical effects of explosions: a synopsis

The following is a brief overview of what happens to a body when an improvised explosive device (IED) detonates. Triggers for IEDs can be pressure plates (where someone steps on a type of solid surface and that action causes the explosion), 'trip wires' (wires at a low height, which can be 'tripped' by a person's leg hitting it whilst walking or running), or an IED can be triggered remotely (by a mobile phone, for example). IED types were different in Iraq versus in Afghanistan (Greaves, 2019). Iraq IEDs were composed mostly of projectiles, which would have caused severe bodily damage but not necessarily loss of limbs. Afghanistan IEDs, which are the type my participants experienced, had an amplified explosive blast, creating greater trauma in the lower body. Blasts have four possible injury paths: primary, secondary, tertiary, and quaternary.

In the primary blast, the blast wave passes through the body, specifically the soft tissues within. According to Greaves (2019, p. 188), 'structures such as the ear, lungs and gastrointestinal tract are at particular risk, and solid organs, including the skin, are more resistant'. The secondary blast follows, carrying fragments of intentional projectiles (i.e., ball bearings, nails, or similar items) as well as dirt, sand, and other debris from the bomb detonation site. The tertiary blast causes injuries to the body by its being projected away from the blast site, often hitting hard physical structures, such as a wall, causing further injury. The last type of blast injury is the quaternary, wherein burning occurs (either directly to the skin, through the clothing, or from other surrounding

flammable materials). Figure 5.1 below demonstrates the four types of injuries associated with blasts:

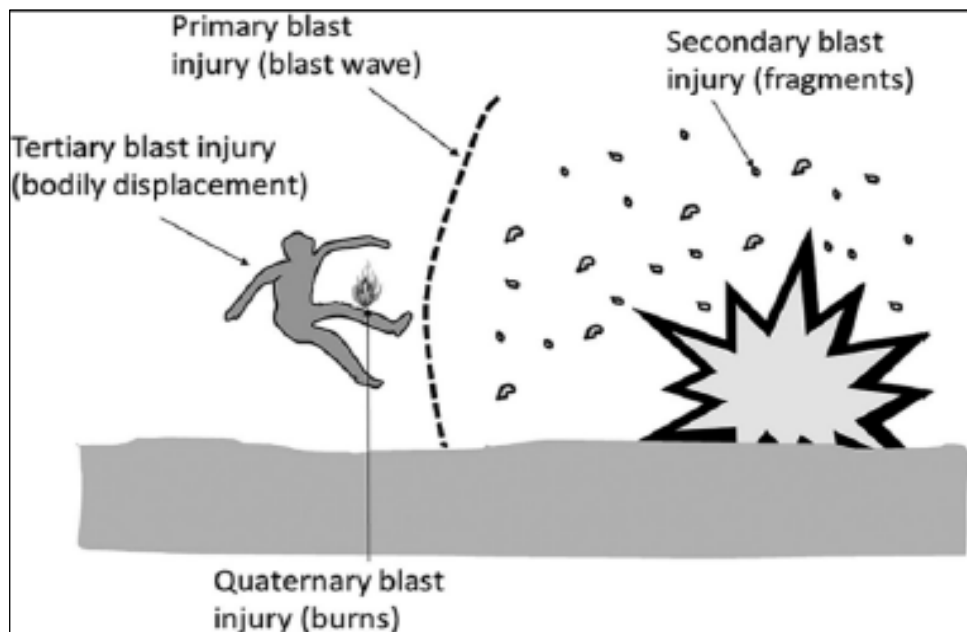


Figure 5.1: Four Explosive Blast Types: primary (blast), secondary (fragmental), tertiary (displacement), and quaternary (burns), from (Stapley & Cannon, 2006).

IED blasts led to lower limb amputations, injuries to the perineal soft tissue, and fractures in the pelvic region (Greaves, 2019). Several of my participants had all of the aforementioned ballistic trauma. It is also important to highlight that the wound was typically contaminated by the surrounding dirt and debris, which was literally blasted into the body upon impact. Numerous surgical debridements are performed in the weeks following the initial injury, cleaning the wound site and necessitating further intrusion into the body cavity, freeing it of contamination, especially if the wound occurred in the Helmand Province wetlands (Greaves, 2019). If wounded in that particular region of Afghanistan, fungal infections developed inside the injured person causing the need for several debridements during recovery. A few of my participants served in Helmand and reported experiencing multiple debridements. An unusual occurrence happened to one of my participants, A.D.: he was injured by an explosion whilst he was inside an Iraqi base, and a

secondary blast wave caused a concrete block to hit the back of his head, producing a neuro-trauma.

Whilst medical care had continually improved during previous combat operations such as World War II, the extensive types of injuries inflicted upon my participants—multiple limb loss—would have been previously fatal (Achter, 2010; Frain, Bethel, & Bishop, 2010; Anderson, 2011; Blackbourne, et al., 2012; MacLeish, 2013; Ladlow, et al., 2015; Greaves, 2019). The increase of combat-injured survivors is what Achter (2010) refers to as ‘the return of damaged or unruly bodies’, which communicate ‘the meaning of contemporary wars’ (p. 47). As MacLeish states, ‘New protective and medical technologies have made previously fatal traumatic wounds survivable’ (2013, p. 54) and the military medical community were able to save lives that in previous wars could not have been salvaged. Addressing the rise in the use of IEDs, their particular injuries, and subsequent mortality rates, the United Kingdom armed forces began training all deployable service personnel on basic life-saving medical care for in-theatre use on their colleagues, but also ‘self-aid’ for when the medic might not be nearby (Mayhew, 2017, p. 26).

One particular item that all troops carried after mid-2006 was a tourniquet, referred to as a ‘combat application tourniquet’ (CAT), which allowed the injured to stop the intensive blood loss within minutes after wounding (Roberts & Berry, 2012, p. 186). Prior to the distribution and use of CATs, the wait for battlefield medical treatment to arrive meant a large percentage of wounded service members haemorrhaged to death. With CAT availability, however, there were an ‘unprecedented number of unexpected survivors’ (Greaves, 2019, p. 42). Several participants mentioned this particular lifesaving technique, either recalling the device being put on their body by fellow service members or actually placing the tourniquet immediately on themselves whilst injured. We learn in these stories, as Wool explains, that ‘bodies in motion can explode, that bodily integrity is not sacred’ (2013, p. 421). Explosive blast injuries prove this unimaginable destruction of bodily integrity by ripping the flesh and ligaments from the bone and, for many of my participants, their limb(s) from their bodies. What follows below are the stories of experiencing a

traumatic injury—in a foreign land or on United Kingdom soil—that changed my participants’ lives and bodies forever.

Narrating the moment of injury

Battlefield injuries

The majority (nine of the twelve) of my participants were injured whilst on operational tours.²³ One (1) participant was injured in Iraq on Operation TELIC, whilst the other eight (8) were involved in some of the most kinetic and volatile deployments in Afghanistan on Operations HERRICK (Greaves, 2019). Participants’ words were very moving and sitting with them whilst they told their stories was a remarkable research experience. Whilst some of their stories might read very similarly, each experience was very distinct to the participant and the years immediately following, especially with regard to their rehabilitation.

Participants’ stories were sometimes vivid, evoking sights or sounds, and at other times very succinct without much detail. When asked to tell me what happened on the day they were injured, numerous participants sounded rather practiced whereas others navigated their way through the story whilst telling me. It was during this time that they came ‘to be’, as Frank suggests, ‘in the process of the life story being told’ (1995, p. 61). My participants expressed what MacLeish asserts, that ‘[d]espite all the armor [sic], the body is open to a hostile world and can collapse into bits in the blink of an eye, at the speed of radio waves, electrons, pressure plate springs, and hot metal’ (2013, p. 87). It is through participants’ stories that the listener can begin to imagine and understand this violent bodily transformation and disfiguration.

Six of my twelve participants are, in one form or another, public speakers and have told their stories in front of large and small groups, such as business, school, and other organisations. Some are paid to speak whilst others do the speaking as a service to others. Participants such as

²³ Participant injury information is listed in Table 4.1 in Chapter 4.

Jon and Andy were quite comfortable in their narrations because they speak publicly about their injuries. Jon said, *'At the end of the day, all of this is how I earn my living now - doing my talks and stuff like that.'* The reality is that by repeatedly speaking in front of audiences, participants can engage in an verbal, staged, 'autobiographical performance' of storytelling about an extraordinary event and how it changed their lives (Langellier & Peterson, 2004, p. 220). This narrative 'performance' is only possible because the story has already been 'lived through the body as meaningful' and the participant (the 'storyteller') is 'both a narrator and a character, both a speaking subject and a subject of discourse' (Langellier & Peterson, 2004, p. 9). My participants who have told and re-told their stories before audiences are able to narrate in a more practiced and effortless manner.

Others, however, such as J.D. and J.P., were far less 'rehearsed' as they do not tell their story very often—if at all. Participants who were not 'rehearsed' demonstrated the lack of a certain type of fluidity in their storytelling. It is not easy for some to speak about their own bodies and the 'messiness' of injury because they have personally experienced the fact that their bodily integrity was breached. Describing the sudden disintegration of physical wholeness and the subsequent reality of a disfigured body was more difficult for some participants than others.

Everyone I interviewed wanted to tell me their story because they thought doing so would benefit someone else, as is supported by other research about service members (Carless & Douglas, 2017). My participants wanted their stories to impact others' well-being, whether that is a fellow veteran, an injured service member, or the families of the injured. This type of military community ethos of helping others will be further discussed in Chapter 8, wherein participants narrate their current activities.

I will begin with Mark. He is the first British triple amputee to survive Afghanistan. Mark was very willing to speak with me; rather than meeting in a café, we did the interview in his home, where he could speak freely. Mark began with the fact that the day he was injured was Christmas Eve in 2007. Mark and his team were on foot patrol, in two groups, checking the perimeter around their camp:

Nothing too out of the ordinary. And this one was actually a lot easier than any of the ones we'd done to this point. There wasn't really a mission behind it. It was just kinda like, leave camp, you know, walk around the immediate area for a little while, come back in, and then close things down, and then go off and celebrate Christmas. (Mark)

Mark, and those with him, thought it was just going to be another tedious patrol before looking forward to the holiday festivities. As the Marines finished their patrol:

Because the group that I was in was on a high piece of ground, we were asked to give cover to the other group, we were in attack, in an advantageous position, we could see all around us. You know, it's a lot easier to fight going down a hill than it is going up a hill... (Mark)

I must point out here that Mark was a participant who always spoke with me as if I knew as much as he did about war experiences and therefore I would understand everything he said so, this quote illustrates that approach—how he assumed I ‘knew’ it was easier to fight downhill as if I was an ‘insider’ to military life (Hockey, 2016, Walker, 2016). Mark continued, explaining how he was in charge of half of the group on the hill and after he gave them orders, he proceeded to get in the middle of all of them in case something happened to ‘the guy in charge’. He continued:

I started walking over towards my position that I selected, and as I got there...I... when I got to my belly, and when my right knee hit the floor, that was when I knelt on an improvised explosive device. So, I knelt on this device. It exploded. And, initially, you can imagine what the ground is like in Afghanistan. It's very sandy, very dusty. There was a huge dust cloud created. So, temporarily, I was blinded. I didn't know what I had done. I wasn't in any pain. And, my initial instinct was that we'd been attacked. So, with the adrenaline spiking, and the 'fight or flight' response kicking in, my immediate thought was 'As soon as this dust cloud clears, find where the attack came from, and then neutralize the threat.' (Mark)

Mark explained the process running through his mind at that point of how he reverted to his training (Hockey, 2016; Newlands, 2013). Mark attempted to see where the attack was coming from, knowing he would need to fight, and continuing to tell himself, *'Turn around, turn around, turn around! Find the enemy. Start shooting!'* He stated:

I kinda knew that, in all that chaos, that while I'm telling my body to do something, it just wasn't moving. You know, I kinda knew that, how my body would have normally moved, that wasn't happening. So, I just kinda waited for the dust cloud to settle, and this is seconds, if that, but, you know, it seemed a lot longer at the time. I just waited for this dust cloud to settle so I could get a grip of the situation and assess it, see what was going on, and then try and make some very quick decisions about what I was gonna do. And as it hit the ground, and cleared, that's when I saw, you know, the state of me and the damage, and kinda realized what it was I had done. And that we hadn't been attacked, and I had stood on an improvised explosive device. (Mark)

Mark explained the care that his fellow Marines took in ensuring the medic could reach him. Once the medic arrived, Mark said:

One of the things that they are trained to do with a causality like me is to try and get you involved in your own evacuation to, to keep you conscious and responsive. So, he asked me to tighten up the tourniquet on my arm. And so, I didn't do a great job of it, but I just did it to please him. And then he laid out a stretcher, which was not like you'd imagine—like the rigid stretcher—because we were in a giant hole in the ground now, so it was more like a bedsheet with handles on it. And then he dragged me onto the stretcher. Now, as he did, I felt a really sharp pain in my right leg. (Mark)

And this placement upon a stretcher is when Mark's story was not what he expected:

So, I looked down, and, coming out of my thigh, was like a piece of string, if ya like? Covered in claret and sand...and I followed it in the ground and it, it went into a boot, which I picked up. Had a look inside and it had my foot in it. And so we had to cradle it on my stomach cuz it was still attached to me somehow, um, and caused a lot of pain, so he put it on my stomach and he proceeded to take me off the high feature, uh, down to the low ground where there was a vehicle waiting. (Mark)

This type of goriness, or the 'grotesque' (MacLeish, 2013) within blast injury narratives is not uncommon and Mark's rendition is a prime example of containing the 'messiness' and horror within the attempt of explaining what it is like to look at one's own corrupted, disintegrated body to an uninjured (whole) person. As MacLeish points out, service members in a war zone have 'no neat division between what gore might mean for a perpetrator and what it might mean for a victim, because he is both at once (..) stuck in the middle of this relation' (2013, p. 85). Mark's telling of his experience about seeing a piece of his body, still attached by some sinew (as he states, 'a piece of string'), and the need to place the foot upon his stomach so he could be carried away from the explosion site places the listener firmly within the gore and messiness of the wounded body—blown up and apart.

On Mark's journey to the helicopter, he almost fell out of the vehicle. When he arrived at the helicopter, he felt the sensations of the propellers blowing sand and heard the tailgate opening and, he said, *'I passed out. Then later I found out that I had died at that point'*. When I asked him about the extent of his injuries, he listed *'Two legs, one arm, some burns, some shrapnel; that's it'*. Time and distance have given Mark the ability of being able to joke with me about his list of Afghanistan injuries, finishing with a 'that's it' as if it were not extraordinary explaining this to another person anymore. Mayhew describes this particular descriptive approach by ex-service members as '[a] flair for understatement' (2004, p. 43). This narrative approach is due to two possibilities. First, the telling and re-telling of the story can create a distance from the incident. As Frank (2017, p. 4) states, 'telling a story of suffering establishes some distance between the embodied immediacy of that suffering and the description of what is happening to a character in the story being told'. Second, during their time in the military, service members learn to hide or dismiss their former bodily injuries for fear of appearing weak and undisciplined (Hinojosa, 2010) or being accused of malingering during a military sick parade (Newlands, 2013).

Jon also survived being a triple amputee from stepping on an IED. Whilst going out on foot patrol, Jon, a former Royal Marines Officer, explains what caused his injuries. He lost both legs and his right arm:

We left the patrol base about 4:30 in the morning in the dark. We were patrolling up to see a local farmer who lived on the hill that overlooked our patrol base and on the other side of the hill was... um a kind of Taliban headquarters for our area, so he used to get a lot of harassment from them. So, every now and again, we'd just go and see how he was doing and that is what we were doing that morning. About a quarter to five the light was coming out, so we stopped to take our night vision goggles off. Um... waited for about ten minutes to let our eyes adjust to the light and then set off again to head to the farm. I don't really know what the time period there was, but sort of within the next couple of minutes of that I stepped on an IED. I was number seven in the patrol, stepped on an improvised mine, and it blew off both my legs there and then and my arm. Um, didn't quite blow it off but messed it up that it was clear there and then it wasn't gonna be saved. (Jon)

As is demonstrated above, Jon told his story without many embellishments. He previously conveyed to me he was a public speaker and told his story as part of that job, so his narrative succinctness was not completely unexpected during our interview time. The level of stoicism, however, was more than I had anticipated; it was apparent the military norms of not complaining were present in his dialogue (Sherman, 2005). Sherman states 'displays of attitude in body language, facial demeanour, tone of voice, and so on are critical elements of doing what is appropriate, regardless of whether they faithfully represent what is inside' (2005, p. 63). Frank (1995, p. 63) asserts that the 'contemporary version of stoicism borders on denial'. This lack of emotion, or what Hinojosa (2010, p. 179) calls 'emotional control', is very common in military men.

Jon, like Mark, hosted me in his home for his interview and that allowed for unlimited and uninterrupted conversation surrounding his story about his injury. I noticed when the recorder turned on, there was a change in him from the conversational, relaxed person to the focussed, deliberative interviewee. He instantly transformed and became the Royal Marine Captain and

Mountain Leader, by the way he sat and the change in his demeanour.²⁴ Jon was not alone amongst my participants in this so-called 'switch' to military mode once I turned on the recorder. Whilst we were clearly not on a battlefield, his behaviour reflected what Hockey (2009) focusses on in his field research on infantry training. Hockey described service personnel 'switching on' whilst on patrol through their 'embodied, sensory practices' of 'moving, seeing, hearing, touching and smelling in a particular occupational fashion' (2009, p. 481). Several of my participants did this observable 'switch' once the interview began, perhaps to focus on their narrative precision. This embodied behaviour was a form of an intersubjective 'bodily engagement', or 'somatic mode of attention' (Csordas, 1993, p. 138) between my participant and myself as the researcher, as we 'attend' to each other throughout the interview by our reactions to, and interactions with, each other. Oftentimes, this 'switch' meant a rather short, precise telling of events and briefer interviews.

Participants who told their story concisely typically stated it in just a few sentences—enough to explain what happened to them but they were neither elaborative nor emotional. For example, Dave was quite brief in his injury narrative:

I was with my search team. We were on a routine planned operation to clear two compounds, ready for locals to move back in. Um, it was a very quiet and normal day. Uh, searched the compound and moved to the interior buildings. I crossed the compound to gain a visual contact with some other Army personnel we were working with, turned back around and I stood on a bomb that we hadn't seen. Um, and that resulted in the loss of both my legs: left leg through the knee and right leg above the knee. (Dave)

Dave is among those who have spoken before various audiences about their injuries (Langellier & Peterson, 2004), so it does not seem surprising to me that he, along with several of my other participants (like Jon, above), tell it in a 'matter of fact' manner.

²⁴ Royal Marine Mountain Leaders are 'experts in Arctic warfare and mountaineering (and) also covert surveillance and reconnaissance'; from www.royalnavy.mod.uk/news-and-latest-activity/news/2013/june/06/130606-royal-marines-look-for-new-mountain-kings

Other participants took more time telling their story, either through describing the scene and feelings, or being quite thorough in explaining it in an almost minute-by-minute fashion. With almost all participants, I could sense they wanted to tell me the story in such a way as to experience the story as realistically as possible. Words, gestures, and emotions were allowing me to ‘see’ and ‘feel’ with the participants as they told me about those moments when they were injured. In this way, narration is an embodied form of communication; ‘Performing narrative requires bodily participation: hearing and voicing, gesturing, seeing and being seen, feeling and being touched by the storytelling’ (Langellier & Peterson, 2004, p. 8). Further, by my listening to the participants’ stories, I was ‘bestowing attention’ on them, which is ‘complex, demanding, and difficult to achieve’ (Charon, 2006, p. 132). Even so, it was the intersubjectivity—the ‘joint being-in-the-world’—of storytelling that connected the two of us in that time and in that place whilst talking about the injury from the past (Charon, 2006).

Andy, a former Royal Marine and single above-knee amputee, also wanted to participate and agreed to meet with me. Andy speaks to audiences about his war experience, his injuries, and what has happened since he was medically discharged. Originally, we decided upon a predetermined amount of time (approximately 45 minutes) but ended up spending much longer together (almost 2 hours), as he wanted to make sure I had ‘*what I needed*’ for my research. We met at a café near his home and it was relatively empty. Fortunately, we had almost the entire place to ourselves, so it was easy to hear him, and he was free to say whatever he liked without being overheard. I was concerned about both when I arrived at the café, as it was not acoustically ideal, and the seating arrangements were quite close together. There was also an upstairs space in the café that was empty but usable, which made hearing and recording a non-issue, but, more importantly, we could speak in a quiet corner by ourselves.

Andy's storytelling was very inclusive. He sustained injuries in-theatre when he crossed a ditch during the early hours of a patrol in Afghanistan. He was following a fellow Royal Marine when they set off a trip wire, causing an explosive detonation:

And I remember the whole thing perfect. I literally remember Ian and he gave me the thumbs up and looking at me to say "I'm gonna jump here." And again, I was like, "Yeah, mate. Right behind ya." Well, as he's leapt over the ditch, I kind of almost led with my right leg to jump as well. And I just heard two huge explosions and I immediately knew, you know, I'd been blown up. I've, I've heard some guys say they, they either don't remember or they didn't know what went on but I straight away just, thought "Fuck. I've, I've been blown up." I fell back and em, straight away I couldn't see anything. My world just turned dark. I couldn't see anything cuz of all the dirt and debris that had gone off into my eyes. (Andy)

Andy's narration included how long he remained aware of everything that was occurring around him, especially the 'lads' who were saving his life, *'They're the real heroes there. They, they'd run forwards to my position and dragged me out of this ditch and began, kind of 40 minutes or so of, of patching me up and doing everything they could to save my life.'* It was within the immediate minutes after being blown up that Andy realised how much had gone wrong for him:

I knew straight away there was something wrong with my right leg. I couldn't really feel any other injuries. I mean, suffered 27 separate injuries at the time: shrapnel to my face, lost chunks out of both forearms, broke navel, broken sternum, eh, broke both lower legs, big chunk out of my left thigh, and also my right. The only thing I could feel was my right thigh cuz I'd severed my femoral artery. So, I had a tourniquet on the top of my groin, which was, you know, stopping me from bleeding out. And that's the thing that I could feel more than anything. (Andy)

Panic set in for Andy as he realised there was a tourniquet on his leg. He told me about watching other medical evacuations wherein a tourniquet was only used on men who had lost a limb:

I just kept on saying to the lads, you know, "Have I got me arms and legs?" And they said, "Yeah, Andy. Don't worry. You've still got them." And was saying "Don't lie to me! Have I still got me arms and legs?!?" (..) So, I was really worrying, thinking the lads were lying to me, that I'd lost the leg. (Andy)

They continued to reassure him as they prepared him for flight and Andy did keep his right leg—for a while. After a complete rehabilitation and his leg being as ‘healed’ as possible, it barely functioned. His original injuries, which did not include the loss of his leg, were several broken bones, multiple pieces of shrapnel to his face, wounding of his arms and thighs, and the severing of his right femoral artery. Due to the extensive damage and the inability to functionally use his injured ankle and foot after several surgeries, Andy opted for an elective amputation in November 2010, which was just under two years post-injury. He made this decision so that he could walk and run with a prosthetic versus walking with a stick and being completely unable to run:

While I was really grateful to be able to walk again, at Headley Court, being surrounded by other guys who were amputees and they were walking around, pain free. They were trying all these new sports to get on with their life. And here's me with this dodgy, dodgy leg that didn't really work. I was also conscious that, later on down the line, I may have to have the leg amputated anyway. (Andy)

This reflection demonstrates the reality that his leg, whilst saved ‘for now’, might still need amputating later in life due to age, pain, or deterioration.

Paul, a Royal Marine, who was wounded on his sixth operational tour, also chose an elective amputation but his day of injury was quite different, and he was very elaborate in its description. Paul’s explicitness in his narrative meant ensuring I understood the moments leading up to the explosion. He also talked about the experiences the days prior to the injury—flying by helicopter into the area, staying with the local residents, and going out on foot patrols—in such a way that focused on the corporeal experiences a person might have lived through or witnessed in a movie. For example, he mentioned the ‘atmospherics’ of being in a place and feeling like something was wrong: *‘[W]hen you sort of live and breathe in these environments for a period of time, you get a sense of when things aren't quite right’*. Paul’s example addressed the type of ‘sixth sense’ people identify in these harrowing situations, such as the ‘uncanny sense of a presence over one’s shoulder’ described by Csordas (1993, p. 139). According to Csordas, this sentient reaction is due

to our bodies being in a world, as he states, an 'intersubjective milieu' with others', wherein we 'attend to others' bodily movements' (1993, p. 139). Paul's reaction highlights the necessity for military personnel to heed—and respond to—these attentive sensory modes, especially in relation to others' bodily movements, due to the fact deployed service members needed to protect their lives and the lives of others in dangerous environments.

To further illustrate Paul's point, he used the example of someone from the city entering a 'cowboy bar' and the mood instantly changing inside the bar, people quieting down, and the jukebox stopping. That illustration is how he prefaced telling me about searching for the Taliban whilst leading his small team through a local village:

And with that, the kids just started running away. And (I) thought, "Well, okay. Even though the Taliban are dicks, they don't tend to blow up children much..." So, we, we had an inkling that something was about to go down and it was then that I followed my eye line off to the right and I could, could just see two guys just got hunkered down in the field. And it just didn't fit. It just, essentially, it didn't fit with me. (Paul)

As Paul told the story, I could guess how his mind must have been processing what was happening in that moment:

I followed my eye line back to the path, to the wall, right next to where I was stood and I could see an oil drum, poking out through the bottom of the wall, which had some like, bush and stuff, to conceal it. And straight away, I thought, "Fuck!" I knew what it was, so I turned and shouted to (fellow Royal Marine) to run and in that one second, like, bang! (Paul)

I noted that his first instinct was to warn his fellow Marines to get out of harm's way before he ran:

In that one second when I saw it, turned and ran, I knew it was an IED. It was probably on a command wire. They would have triggered it then and in that time when I would have turned and ran...bang! Off it went and then shot me like an arrow into the wall, the other side...as I turned around and so I hit the wall with quite a lot of force and that's what broke my neck. (Paul)

Paul had many more injuries from the explosion. His final record consisted of the following wounds: a broken neck, an amputated left leg, deaf in his left ear, blind in his left eye, a severed carotid artery (at 90%), nerve damage down left side of his body, 400 pieces of shrapnel (removed), left frontal lobe destroyed, and the right side of his body no longer functions properly due to frontal lobe issue. After five failed limb salvage surgeries, Paul opted to have his lower leg amputated. He made the decision because it is important to him to be physically capable of interacting with his four young children.

J.P. was one of the youngest participants and was in the Royal Marines for ten years. He also mentions 'sensing' the atmosphere in his narrative, *'And looking back, there was something wrong with the whole scenario cuz the whole marketplace was empty.'* On his second operational tour in Afghanistan, J.P. stepped on an IED. Despite the explosions' significant damage, surgeons saved his injured leg and foot. J.P. was burnt extensively on his face and hands and has one leg that minimally functions. He continued, telling me what happened whilst he patrolled on foot and searched a small village. J.P. indicated he did not heed that sixth sense of *'something wrong'*:

[I]t [the area] was secured by Americans. They sent the dogs through, so I think I just got a little complacent with it, to be fair. (J.P.)

The lack of remaining vigilant became apparent to him:

And then I trod on a device, which it only partially detonated. So, I was very lucky in that sense. So that damaged my left foot. And then, there was like a big fireball. I got burnt in areas. Came rolling out of that. I think my interpreter actually dragged me out of the uh, dragged me out of the crater that I was in. Uh, an American medic patched me up. Uh, first thing I saw, I looked down, my foot was still there so, and my boot was gone but my sock was still on. So, I was like, "Well, this can't be that bad. I mean, my foot's still there." And then it got wrapped up. (J.P.)

J.P. continued on with how he was being medically evacuated when another explosion occurred:

Uh, they put me on a stretcher and went to take me into cover and one of the stretcher-bearers, an American, trod on another device, which fully detonated.

I think he lost his right leg, I believe. Uh, that (explosion) blew me off the stretcher into the middle of the road! (J.P.)

I have condensed some of J.P.'s sentences but left many of his original speaking hesitations to make his narrative style more apparent to the reader. J.P. avoids telling people about how he was wounded, so the fact that he entrusted me to hear his story was significant, as I can be a 'witness' for him and his story (Carless & Douglas, 2017). J.P.'s reluctance and 'uh's' whilst telling about his experiences demonstrated his continuing struggle with articulately forming the story for himself as well as the listener—me, in this case, and he could not 'always tell, in logical or organised language, that which must be told' (Charon, 2006, p. 132), but he was determined to tell me his whole story.

Since J.P. is averse to speaking to anyone about his injury, his slightly disjointed and tentative narration made sense to me after our interview time together. His story is the only one I captured wherein Frank's 'chaos' concept is the most evident, wherein one 'imagines life never getting better' (1995, p. 97). Furthermore, whilst J.P. had not experienced an amputation—yet—he has lost the complete, unrestricted use of his leg. Similar to those who have lost a limb, due to his debilitated leg, he has 'experienced a shrinking horizon of possibilities' (Messinger, 2010, p. 284) of what he can do in both his near- and long-term future. J.P.'s inability of being a Marine anymore—or anything close to resembling one—in addition to his lack of 'knowing' his future was profound and will be discussed further in chapter eight.

In another story, Ken, an improvised explosive device (IED) Disposal Operator in the British Army, told me about the day of his injury in an Afghanistan field. Whilst Ken survived, his Search Team Commander did not. Ken was trying to save him from an IED when it exploded. His bomb disposal team was supporting a unit that had come across six (6) IEDs whilst on patrol. Ken said it was '*pretty standard, run of the mill...normal kind of day*' for what they typically dealt with on a regular basis. But as he continued telling his story, the momentum changed. He began by being very thorough in explaining the methods of checking and clearing out areas identified as having

IEDs. His team found several devices and disarmed them. Then, as he was beginning to get close to the part of the story where the injury (and his colleague's death) occurred, his tone and urgency changed:

I went forward to help him and then I when I went forward, I could see um, instead of it being like a, a like a raggedy hole, like an animal hole, the, the edges of where his feet were in, his feet had also gone down into the ground, it was quite clear to see square-cut edges, um, and, man-made, obviously. The only reason for it to be there was...is there is a bomb under it. (..) Pretty much every [device] I've dealt with was a circuit, so my thought was, if I got a single wire, I'll take the risk and I'll probably be 99.99% correct that this is a, is a single-series circuit, there's no reason for it not to be. It was the only choice I had. (..) Unfortunately no wire popped up. Um, I couldn't dig. We just didn't have the time. (..) This IED had been disturbed. We didn't know why it hadn't functioned. We didn't know if it would function at any second or what...um, and I just thought we had to get out of there. So I, I tried to grab him to lift him and, and then as we were doing that, that's when the device exploded. And it threw him into the river that ran adjacent to the track. Um, and it was just me, as, as, as it is. (Ken)

Ken's story to this point told more about his responsibility and reaction to a fellow soldier. When he described his injuries from the IED explosion, it became clear how extensively damaged his body is. He sustained the loss of both legs above the knees, genital injuries (loss of both testicles), an open pelvic fracture, hips fractured, right femur fractured, perineal injury, intensive soft tissue injury, loss of both thumbs and several fingers, extensive nerve and tissue damage in hands, almost deaf in his right ear, and his forearms damaged. When I interviewed him, he was still not finished having corrective surgery on his residual limbs.

The surface of Ken's body illuminates the point made by Kinder (2015), wherein 'the human body remains in a state of perpetual and visible change. Scars rupture, heal, and rupture again; old injuries are overlaid with new ones' (pp. 195-196). At the time we spoke, Ken could not be properly fitted nor wear prosthetics due to the fragility of his skin on his legs, which still needed surgical repairs. His skin tore apart at the site of the stitches and there was a continual battle against infections. Even under normal circumstances, as Kilshaw (2007, p. 256) states, 'Body boundaries

are porous, allowing dangerous external elements to enter', but the body becomes a site of more precariousness after being blown apart by an IED as Ken's body attests.

Ken was unsure when he might be scheduled for the necessary corrective surgery. His life was in a constant state of disruption (Bury, 1982), or as Hollander and Gill argue, 'the state of biographical disruption threatens to become a permanent state of being, both in the context of conflict and in the postconflict [sic]' (2014, p. 222). His frustration surrounding the inability to plan for surgery was evident, especially because it also directly affected his wife, who cared for him. They were both in a 'temporality of power' (MacLeish, 2013, p. 98), wherein they were held, powerless, in a system because they must wait—for an unknown length of time for an unknown physical result.

The following two participants, Pav and A.D., do not have visible injuries that would be immediately obvious to the casual observer. However, they both have extensive physical damage from bomb injuries. Pav, a participant who served for two decades in the British Army, was leaving Camp Bastion in Afghanistan when a suicide bomber hit his vehicle. Classifying himself as '*quite a bit scraped*,' the injuries he sustained were a broken back, perforated eardrums, burst blood vessels in his eyes, and tinnitus. Trained as a medic, he also saved other soldiers immediately after the bombing. The results of this incident were such that he developed incapacitating back spasms, needed a bone graft in his spine, has permanent pain, and experiences re-occurring kidney stones—some of which must be removed surgically.

I'd left just to go back to the Afghan camp. I was in the lead vehicle, um, when a white Toyota Land Cruiser - like this is after the fact, I didn't know it was a white Toyota Land cruiser, obviously. I didn't see it. (...) There were other vehicles behind us, um, one had approximately 20 guys in a soft-skinned vehicle so no protection at all. (...) The white Toyota Land Cruiser basically contained a member of the Taliban or Taliban sympathiser, uh, target(ed) the vehicle I was travelling in. Rammed into the vehicle and detonated what was a vehicle suicide bomber. I didn't really catch the 'bang' of it. (Pav)

He continued on, explaining the experience inside of the vehicle:

Flames ripping through the vehicle, a fireball and everything like that. And I was aware.... sounds bizarre, but I had to get out of the vehicle. I didn't want to burn to death or anything like that. (Pav)

It was in these moments of our interviews that I realised that their ability to utter phrases such as 'I didn't want to burn to death or anything like that' were considered normal for the majority of my participants.

Unlike all of my other participants, A.D. has no recollection of the actual event wherein he was wounded. A.D., a Royal Air Force fighter pilot, who experienced a severe diffuse axonal injury (a traumatic brain injury, or TBI) whilst in an Iraqi Forward Operating Base. He was initially, and immediately, flown to a Saudi Arabian hospital but two weeks later returned to Birmingham, England, without any documentation or medical notes (and, he noted, still in the desert flying suit he was wearing whilst injured). His narrative is based on the reconstructed stories of his fellow service personnel whom were present during his polytraumatic injury:

I don't remember it at all, but I know what happened, Yeah... [an] explosion on the ground. Chunk of concrete to the back the head. Flat, luckily, so not fractured at the back (of the head). Just lots of bruising and stuff, but countless injuries in my head: moving forward, brain stayed where it was and went back, and obviously, replaces itself so had multiple little bleeds in the front - both frontal lobes - and lesions down near the base and the back, I can't remember what it's called....I can't remember... (A.D.)

Throughout A.D.'s interview, he repeatedly said, 'I can't remember' and so his telling was pieced together like a collage. Some were his memories and experiences, but many other portions of his story were what he was told by people whom he trusted—his military 'family' (Ahern, et al., 2015). When he has specific memories, he elaborated as he did below, explaining what the process of arriving back to the United Kingdom was like for him with a TBI and a lack of medical records:

But basically, what happened was I got aero-med-ed back, I was on the stretcher, an ambulance stopped from Bryce Norton, yeah Bryce Norton, which is an Air Force Base, to uh, Birmingham to Selly Oak, as was. [I was] brought to A&E, and they went "And you are? Who are you? Why are you here?" I had, still had my desert flying suit on, suntan, here—wrists and face—white

everywhere else, still with literally pink sand everywhere from the desert and all my flying kit, for four months or whatever I deployed for, so you can imagine the amount of kit. Um, and A&E go, with still neck-brace on and completely, utterly confused by life, post-brain injury, and um, so I really didn't know why I was there, either... So, I wasn't very helpful. No paperwork whatsoever had come back. No medical notes, no nothing. (A.D.)

A.D.'s struggle to recall anything that happened made it more difficult for his recovery. A.D. did not receive proper diagnosis until seven years post-injury, during which time he developed epilepsy with Tonic Clonic Seizures²⁵, tinnitus, loss of balance, and vision loss. His seizures also further physically harmed him, causing a dislocated shoulder and, because he was holding a knife at the time of a seizure, cutting off a fingertip. Without a proper diagnosis, A.D.'s TBI went undiscovered and undiagnosed for several years and he faced increased problems—physically, mentally, and emotionally. Further, this affected his interactions with his family due to 'residual emotional/behavioural problems' that continue to place stress on both the person with the TBI and their family members or carers (Cavallo, Kay, & Ezrachi, 1992, p. 328).

Homefront injuries

Three participants had injuries that they sustained in the United Kingdom at various points in their careers. J.D. was involved in a car accident, Lee was hit by a car on the side of a motorway, and Colin was injured in basic training (although served an entire career before being impacted by it). J.D.'s injury happened whilst driving home from a military function. After several months of training in Belize and the Outer Hebrides, a new shift-work schedule (twelve hours working out of twenty-four), and a new training course, J.D.'s body had reached its physical limitation. He told me that he had gone to a regimental dinner:

[I] passed my selection board; finished that on late Friday night. Got home about 5 o'clock Saturday morning. And there was a regimental dinner on the Saturday night, which I had to attend. (..) Um, you couldn't leave before the

²⁵ He described these as: 'a violent seizure, complete loss of consciousness, [and] complete loss of all bodily control.'

RSM (Regimental Sergeant Major). The RSM was uh, 'in for the night' so I got away about 4 o'clock in the morning...because I was living away, I didn't drink. But I was very tired. Uh, went to drive home. Got about10 miles. Fell asleep at the wheel. Came off the road and hit a tree. So, then, that was it. Car folded. Folded in two. I was only doing 30 miles an hour, so the police say, but it was only a small car and that was it. (J.D.)

J.D.'s left tibia and fibula were broken, and he had to have approximately two inches of bone removed. Both ankles were broken. He had several surgeries to repair his legs over the next few months. But J.D.'s worst injury went undiagnosed for at least three years after his accident, which was a traumatic brain injury (TBI). Due to his TBI, he continues having cognitive issues, such as forgetting the cooker is on, which placed stress on him whilst he cares for his wife; however, he has found a 'work around' by using only the kettle or the microwave to prepare meals (since they 'turn themselves off'). During our interview, he would admittedly 'stray a bit from the question' and, with a little re-direction or reminding from me, we would get back on course for his continued narration. J.D.'s TBI impacted his life on physical and mental levels. His fatigue, forgetfulness, and lack of concentration are the problems he mentioned to me and are common effects from a traumatic head injury. As Cavallo et al. state, '[P]oor balance, doing things slowly, being forgetful, word-finding difficulties and changed personality' are issues that become apparent to both the injured and their families (1992, p. 332).

Lee's injury also occurred in the United Kingdom. He had served in the Royal Marines for over twenty years at the time of the accident and was subsequently medically discharged. He was returning to duty when he was injured. As he was on his way, he came across an accident and stopped to assist:

I was helping the people who had come out of that vehicle, making sure they were okay, when another car crashed into that one and the engine block and gearbox came flying out. And it was the engine block that struck me... more or less, completely severed me right leg and completely dislocated me left leg. [I] managed, with a passer-by, to try to get a tourniquet on, um [and] that wasn't working. Couldn't get it tight enough so I got his daughter to stand on my femoral artery, which is near your groin, and that's what saved my life. Waited about a half hour, twenty-five minutes for an ambulance to turn up. So, I, and

this is kind of, this is the very, very, very, very important point I believe that I fought like buggery to stay alive. So, when I woke up in hospital the next day, it was a case of "Ah, me leg's gone but fuck that! I'm alive!" (Lee)

Lee's narration demonstrates an unusual story in that he sustained his injury by helping others whom he thought might be injured in their accident. In fact, he almost lost his life from the experience. Then he also attempted to save his own life by instructing the passer-by on how to apply a tourniquet. When that was ineffective, he coached another passer-by, having her literally stand on him, slowing the life-ending blood flow out of his leg. Ensuring I understood how he fought for his life was a 'very, very, very, very important point'. Lee's pragmatic, yet obviously determined, response to losing a leg versus losing his life is evident in the proclamation.

Another participant told me the story of his multiple injuries he experienced whilst in the United Kingdom. Colin's first injury occurred whilst he was in basic training for the British Army, '*It was in the days when we carried telegraph poles on shoulders... the other guys carrying it slipped and I, I took the weight of the telegraph pole on the base of my neck.*' He subsequently left the Army. After a year of physiotherapy, Colin joined the Royal Air Force. He served without physical ailments for almost twenty years, and then the initial injury from his Army basic training emerged:

The injury was uncovered in 2006, while walking a dog on a lead. And he went for a cat and basically pulled my arm backwards and downwards and it caused a nerve in my neck to move into the way of the damage that had been made when I was in the Army. So, I'd grown osteophytes, where the vertebrae are trying to stabilise themselves and they were and still are affecting the nerve into my right arm. (...) The second injury was while I was off for the first one, so [in] January 2007, I prolapsed a disc at L-4, L-5. [I] wasn't seen by a consultant for eight months, during which time I got permanent nerve damage in my left leg. (Colin)

Whilst not a typical service-related injury, Colin's experience left him with such pain in his lower back and leg he was no longer fit for duty. The initial traumatic injury during basic training in his youth remained undiagnosed until a small, rather mundane occurrence of the dog dashing away on the leash set off a chain reaction—ultimately causing a medical discharge from the Royal Air Force

at the height of Colin's career. It also negatively impacted his operational deployability, which meant his injury affected his team. Colin stated that someone else deployed in his place, as the 2006 injury occurred just weeks prior to a scheduled deployment, and that he felt responsible for having sent another person into danger.

Initial Experiences in defence medical rehabilitation centres

Pathway of care and rehabilitation: a synopsis

This section will present a brief overview of the experiences that my participants would have had entering into—and within—rehabilitation centres. Whilst not intended as an extensive, comprehensive explanation of everything associated with military medical rehabilitation, this section will highlight some features of how participant lives were saved immediately following an injury as well as the physical rehabilitation provided. Additionally, rehabilitation will be further discussed throughout the following chapters.

After the injury occurs on operations (deployment), the service member is evacuated and stabilised. For those severely injured, they were put into a care pathway leading to their return to England, specifically, to the Royal Centre of Defence Medicine in Birmingham (Dharm-Datta, Etherington, Mistlin, Rees, & Clasper, 2011). The United Kingdom's military clinical care pathway consisted of four (4) 'roles' of medical support (Greaves, 2019, pp. 42-79). Put simply, the roles were thus:

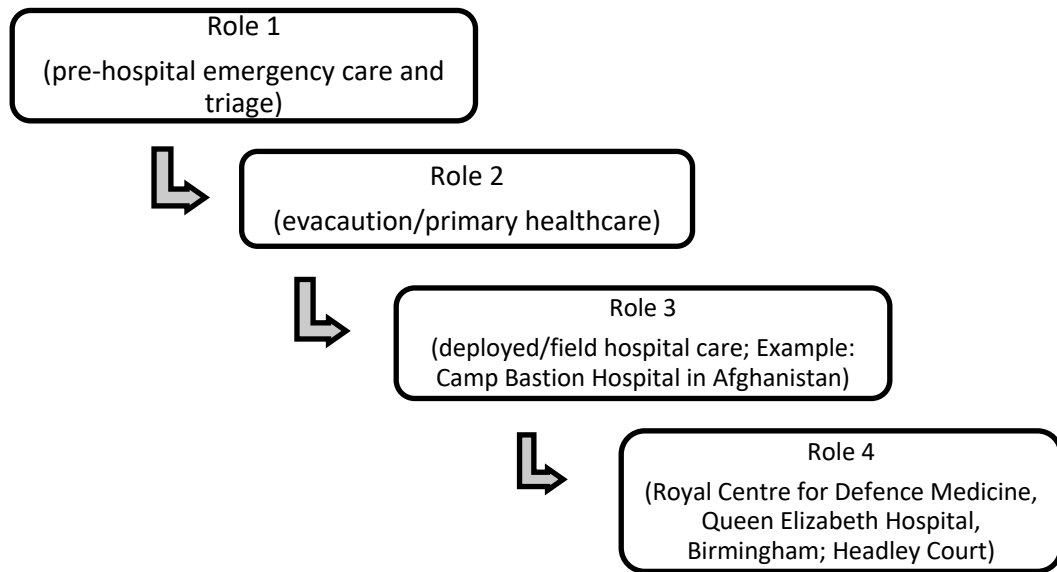


Figure 5.2: Pathway of care for injured United Kingdom Armed Forces service personnel during Operation TELIC (Iraq) and Operation HERRICK (Afghanistan). Created from (Greaves, 2019, pp. xlii; 46-77)

For those injured whilst on operations, their first surgery occurred in-country before being sent to the Queen Elizabeth Hospital in the United Kingdom (Roberts & Berry, 2012). At Queen Elizabeth Hospital the injured received ‘definitive surgical treatment’ (Dharm-Datta, Etherington, Mistlin, Rees, & Clasper, 2011, p. 1362), or surgeries to salvage limb length and internal organs, skin grafts, and, in general, create a body that would still function. It was ‘the power of modern medical technologies to literally remake a body out of its ‘spare’ parts’ (Gilbert, 2014, p. 152).

Once their body was at a point where physical rehabilitation could begin, the service member was referred to the Defence Medical Rehabilitation Centre (DMRC) Headley Court in Surrey (Etherington, Bennett, Phillip, & Mistlin, 2016; Dharm-Datta, Etherington, Mistlin, Rees, & Clasper, 2011) in order to have an ‘intensive rehabilitation program focused on achieving high levels of functionality’ (Jarvis, et al., 2017, p. 1390). Upon arrival, they would have a designated interdisciplinary team, consisting of ‘medical, physiotherapy, prosthetics, occupational therapist, exercise rehabilitation instructor, social work, mental health support, and welfare service support’ (Ladlow, et al., 2015, p. 2050).

Rehabilitation transpired in rotations, much like operational tours—the service member was admitted to DMRC Headley Court for a set number of weeks, went home for a short time, then returned for more rehabilitation at Headley Court. These DMRC stays typically lasted around four weeks, with two or more weeks at home. The cycle continued until the medical team decided the rehabilitative goals were met and the service member/patient was released, either back to their unit or to home. Rehabilitation can be ongoing until a medical discharge from the armed forces transpires. Many of my participants indicated they could shorten the length of their stay at Headley Court or decline returning to rehabilitation by increasing their time at home. Negotiating a slight deviation from the normal admission, Dave said, *‘For me, I lived close to Headley Court, (...) so six months post-injury, I commuted to Headley Court rather than stayed.’* Figure 5.3 below demonstrates the military recovery and rehabilitation pathway for serving personnel, from leaving Birmingham to incorporation into the National Health Service after their medical discharge:

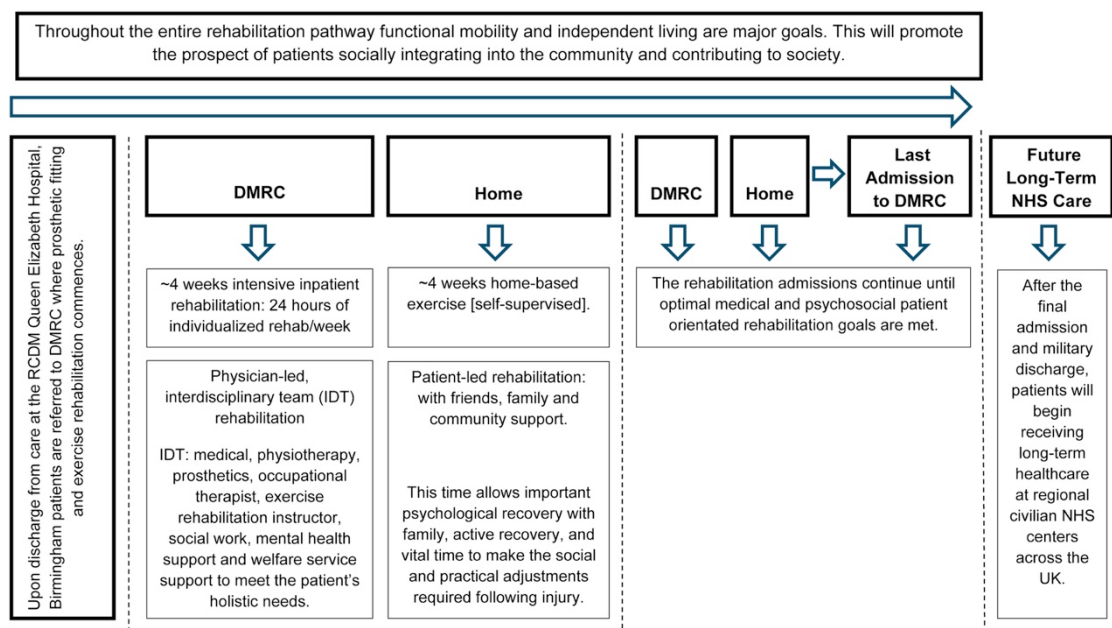


Figure 5.3: “Paradigm of UK military rehabilitation at DMRC Headley Court, 2006–2015. The NHS is the publicly funded national health care system. The organization provides free or low-cost health care to all legal residents of the UK.” (Ladlow, et al., 2015)

Military rehabilitation can be examined as a continuation of an institutional experience due to the shared environment and goals, even though service members may have different injuries. As Wool (2015) suggests in her US military research, as is found in my current research, there is some homogeneity in service members' rehabilitation experiences, but there are also differences due to the type of injury. For example, two injured service personnel, each with an amputated leg, may both have physiotherapy with the same therapist in the same room but have completely different rehabilitation experiences depending entirely on the length of their residual leg (also referred to as a 'stump'). Whilst two service members may both be unilateral transfemoral (single, above-knee) amputees, where their leg ends will impact how mobile they can be as well as if there is a possibility of using prosthetic(s). If there were no adequate residual limb to be properly fitted with a prosthetic, the person's options are using a wheelchair or crutches for transporting themselves. In other words, the closer the amputation is to a person's hip area, the less likely they would be to have—or be able to effectively use—a socket and prosthetic leg. Another example of differentiation amongst post-injury experience is when some amputees develop a painful type of bone growth, called heterotopic ossification, whilst others (who have had the same type of surgical limb removal) may not have this physical occurrence. Injuries may resemble each other but how the body and individual respond to them can be quite heterogenous. These differences are reflected in their recovery pathway.

Rehabilitation, functionality, and prostheses

Military rehabilitation and recovery are attained when an injured body returns to independent functionality. According to Oliver (1996, pp. 36-37), 'The whole medical and rehabilitation enterprise is founded upon an ideology of normality' and the goal is to 'restore the disabled person to normality, whatever that may mean'. In the patient care pathway from injury onward, Bricknell (2014) asserts that medical practitioners and surgeons switch from live-saving issues to functional ones, 'As the patient stabilises, the clinical focus shifts to restoring physiological

function through clinical care and medical evacuation’ (p. 65). As such, Frain, Bethel, and Bishop (2010) maintain persons in the rehabilitation profession are ‘in an ideal position to provide appropriate services to disabled military veterans who wish to return to gainful employment and a rewarding quality of life’ (p. 13).

It is important to note here that the bodily site where the amputation occurs impacts the type of prosthetics an amputee can use. Jones (2013) states, that for those injured on the battlefield, ‘Orthopedic [sic] surgeons leave as much as they can, knowing that the more a soldier retains of his own legs and arms, the easier his rehabilitation will be [...] it helps a lot to have a knee, or two, or part of a hand’ (p. 40). For example, Andy and Paul have below-knee amputations and that means they are missing only one ankle. Another participant, Dave, has one knee and part of the other, so his joints were still present for his two prosthetic legs. Above knee is the most difficult—due to losing all the joints, affecting walking and running. The length and shape of the residual limb determines mobility possibilities due to fitting the sockets appropriately during rehabilitation and afterward. If the injury is closer to the hip, there is a shorter residual limb, which makes prostheses fitting and subsequent mobility more challenging because it is not a prosthetic limb for aesthetic purposes but meant to be functional and ambulatory.

Complex trauma patients from deployments on Operations TELIC and HERRICK were rehabilitated at Headley Court, and this assessment below demonstrates the ideology behind discharged amputees as needing to be functional and not dependent upon public welfare programmes:

“[o]ver 90% ($n = 59$) of amputees, around half those with multiple limb loss, walked independently over all terrains, and 75% (6) of triple amputees did not require a wheelchair for daily activities. This dispels the popular view that these seriously injured patients are likely to become dependent on the state for long-term social care and civilian rehabilitation services” (Greaves, 2019, p. 434).

Medical narratives, like the one above, imply a rehabilitated person is not reliant upon state-provided welfare (because they are capable of being employed) and independent, (independently mobile). The assertion here is that the popular belief is that the ‘seriously injured patients’ mentioned in the quote above will need the care of the state versus continuing to be an independent, productive member of society. Narratives such as this appear more political, as they build upon, and into, ‘controlling perceptions’ (Achter, 2010, p. 58) of war-wounded bodies and avoids the ‘unruly trajectory’ that has a ‘murky, inconclusive end back in a present in which no clear narrative has yet been crafted and yet much is clearly at stake’ (MacLeish, 2016, p. 280).

Another example of functionality and mobility is from Ladlow et al (2015), who state, ‘Patient mobility is a critical component of successful rehabilitation and vital in aiding ADL [activities of daily living]. Therefore, functional levels that allow community ambulation should be the minimum requirement of a successful rehabilitation program’ (p. 2053). Additionally, Wool’s US research claims that an injured veteran’s gait is indicative of liberation, as:

[T]he evaluation of movement through space is one of the main ways rehabilitation is measured. The question of how, and how well, one walks is a powerful index of progress toward recovery, a state that entails the normative appearance of bodies in motion drawn from an ideal elsewhere in the ordinary (2015, p. 134).

For my participants, this type of ‘ordinary’ physical movement from their pre-injury lives is no more; they have learnt new ways of being in the world through adaptation. Below is a table demonstrating my participants’ use of various assistance devices and if they would be considered independent or ‘functional’ (independently mobile daily): *(Table on following page)*

Independence & Assistance Device Table

Types of Assistive device(s)	Number of participants using device(s)	Number considered Independent with device
Prosthetic leg(s)	4	4
Prosthetic legs (with MPKs) and prosthetic arm	2	2
Wheelchair	1	0
Assistive device (stick, mobiliser, scooter)	3	2
Assistive device (brace)	1	1
Assistive device (orthotics)	1	1

Table 5.1: Types of assistive devices and independence (MPK is a micro-processing knee)

Prostheses, technology, and enablement

After injury, my participants were left with damaged bodies that the military medical system attempted to remedy. For most participants, they have mobility via technology, which means adapting to newer prosthetic limbs will allow autonomy. This belief, however, is not without problems as prosthetics ‘promise disabled veterans [...] the fiction of wholeness’ (Kinder, 2015, p. 35). Kinder indicated that, regardless of the best attempts at using prosthetics to complete a fragmented body, the fact remains that a body missing a limb (or limbs, appendages, eyes, etc.) is still not a whole body. Woodward and Jenkins (2013, p. 155) state ‘military equipment’ such as weapons, ‘are [sic] seen as extensions of the physical body’ so, too, are prostheses worn by wounded ex-service personnel (Wool, 2015, p. 137). The technologically enhanced prosthetics assisted several of my participants in adapting to their changed body. For example, the ability to set a prosthetic leg into ‘driving mode’ in order to independently drive a vehicle. Andy (single leg

amputee) stated the realisation of his body being 'broken' in war and what that means to him as he processed what happened:

[P]ersonally, I didn't need anyone to tell me... I wasn't stupid... You know, I took such pride in being this naught point naught one percent, part of the elite. And when I looked down on my body, and a leg was hanging off and I had all this metal work going on and I knew straight away that the chances of me still being a Marine were slim to none. (Andy)

Whilst Andy recognized pragmatically that his body's limitations meant his military career was ending, he would '*not let someone look down on him for having one leg*', which actually motivated him to pursue running post-amputation. I turn to the concept of masculinity, specifically militarised heteronormative masculinity with regard to the post-injury embodied identity of my participants. This 'unmooring of masculinity' (MacLeish, 2013, p. 20) takes place in the social sphere, wherein Andy's response was to not allow anyone to judge him and 'feel sorry for him'. For Andy's life story, his prosthetic leg enables—not disables—him. Andy's narrative was reflective of Achter's 'comeback narrative' (2010, p. 63). Achter investigated US veterans who were injured in war and subsequently presented to the public alongside the President of the United States as 'whole', 'fixed', and heroic; Achter claims it 'tames the harshness of their injuries by translating extraordinary injury into an ordinary but random obstacle' (2010, p. 57). This presentation is problematic, however, as Achter argues that it changes the discourse surrounding the injury's cause (war) to one of personal struggle, wherein the 'problem [is] already overcome' (2010, p. 51). To speak to some of my participants, such as Andy or Mark, their problems have been 'overcome' because of their ability to use prosthetics every day.

Mark also expressed that, whilst it was initially frustrating to use his prosthetics, he has learned that he has been able to return to his physical activeness because of them:

[T]he first time I tried walking with prosthetics it was so frustrating, cuz I was like "[W]hy's this so hard? I'm one of the most physical people on the planet. I'm fit as hell and I can't do this!?" And now, it's normal to me. (...) [A]t the doctor..they told me..that my resting heart rate is the same as an Olympic

athlete cuz of the energy it takes to do this [use prosthetic legs] and I've built myself up to that. (Mark)

As mentioned previously, the process of basic training is an embodied process, which transforms the civilian body into a 'military operative' conditioned 'to endure fatigue, stress, pain and injury' (Woodward & Jenkins, 2013, p. 154). This transformation is when the civilian 'habitus' (Bourdieu, Calhoun, LiPuma, & Postone, 1993) experiences a 'shock of entry', quoting a Lieutenant Colonel, because it is subjected to military culture through basic training and all that encompasses: subordination, new schedules, physical routine, and discipline (Cooper, Caddick, Godier, Cooper, & Fossey, 2016). MacLeish (2013) aptly describes military habitus as 'an ability to take in the sensory indications of danger and act on them without having to think too hard about it first' (p. 76). Further he postulates, 'Operating in conditions of exposure demands a complex synthesis of practical knowledge, emotional discipline, and bodily disposition' (2013, p. 77). Cooper et al. (2017, p. 54) label this as 'the legacy and influence of military culture'. Kilshaw (2007) states that veterans' previous military practices 'were dependent upon their body and its ability to perform. This notion of masculinity is linked with strength and fitness externally and internally' (p. 256). As Mark perfunctorily said:

I boxed in the Marines—kickboxing, Thai-boxing—that's what people knew me as. I was the night club doorman, the bodyguard, the Royal Marine. And now I felt people were just looking at me as this bloke who couldn't even tie his shoelaces. (..) I felt like they pitied me. (Mark)

Mark's past physical abilities of handling 'the rigors [sic] of a military lifestyle' and his 'physical ruggedness' were directly related to his military identity, which continued to be a part of his narrative (Hinojosa, 2010, p. 184). The characteristics, argues Hinojosa, of having a 'physically able and fit body inhabited by a disciplined self' are what constitute 'hegemonic' and hierarchical masculinities that are constructs and 'configurations of everyday gendered social practice' (2010,

pp. 181, 184). The majority of my participants retained this sense of embodied identity through the use of prosthetics.

Prosthetics, argues Caso (2016, p. 218), allow injured veterans to 're-embody militarized [sic] masculinity, despite their physical injuries'. This form of 'post-human techno-masculinity' is accomplished through the use of technology, specifically via prostheses (Caso, 2016; Masters, 2005). This construction of a new form of masculinity is aided by the military organisation in rehabilitation and onwards, by the provision of the most technologically advanced prostheses. It continues past rehabilitation as a policy and is stated that the NHS 'will be able to use this [funding] specifically to access the latest technology and provide the highest quality of prosthetic care for veteran amputees' (NHS England, n.d.). Additionally, Caso highlights the concept originally put forth by Masters' (2005) concept of a 'cyborg soldier', which is created by—and through—the use of prosthetics that 'techno-masculinise amputee veterans, for they re-masculinise veterans by rehabilitating them, and buttress the power of the state as the producer of heroes.' Historically, wounded veterans are 'cultural signifiers of heroism' (Anderson, 2011, p. 50) and the use of cutting-edge prosthetics can restructure the narrative from 'victimhood' to 'technoheroic redemption' (Cree & Caddick, 2019, p. 3), found in the international examples of the Wounded Warrior Games (USA) and the Invictus Games (United Kingdom). These Games bear witness to the remaking 'through performance using narratives of overcoming and redemption' (Cree & Caddick, 2019, p. 3). Some of my participants were competitors in these Games (which will be discussed later in the thesis) and had mixed reactions concerning their experiences.

Another issue participants mentioned focussed upon their loss of the 'breadwinner' status, which Sasson-Levy asserts is a traditional construction of masculinity and can be combined with 'armed masculinity' to fully 'provide for one's family' through military service (2003, p. 333). Pav spoke about his being the 'provider' and taking care of his family and its financial needs, only to have the roles reversed:

When you've been - not trying to be sexist or anything or Alpha Male but- I was the provider for my family. I was the dad. I fixed things. I provided. I paid the bills. And all of a sudden, I'm relying on my daughter, you know, who's seven years old, being part of my care team. It, it...and it's incredibly hard to get over that. You don't, you don't envisage it. You understand that you could get injured um, seriously injured, obviously killed...but at no point before injury do you think of the impact it has on those around ya. (Pav)

Pav's quote encapsulates the undoing, or 'unmaking' of militarised masculinity (Bulmer & Eichler, 2017) for him and his identity due to his spinal injury and subsequent inability to physically care for himself or provide for his loved ones. Anderson (2011) asserts that 'economic normalcy' and 'sport' (mentioned above) are the two ways in which wounded veterans are able to 'demonstrate their masculinity' (p. 56). Pav, whilst acknowledging limitations in physical movements, has participated in recent Invictus Games. Physically excelling through sport, specifically the Paralympics, is mentioned by Dave:

I am a funded athlete. I'm funded by UK Sport, as part of the British Athletics Paralympic World Class Performance Programme, so, currently I'm training for the Tokyo Paralympics in 2020. (Dave)

Dave stated that his training is part of his routine, with specific sport days during the week. The fact that Dave is funded meant that he did not need to worry about a 'regular' job because his current 'job' was being a para-athlete, which was possible due to his continued physical ability and his prosthetic legs. As is mentioned above, Dave's narrative is able to be remade as 'overcoming' the injury—and still being a 'provider'—through his continued achievements in sport.

Adaptation through continued physical and mental military routines

Participants were asked about their basic training experiences and if that experience impacted their rehabilitation in any way. In most cases, the participant stated it was a positive influence for his overall rehabilitation. Some participants focussed on the experience of military discipline being beneficial to their recovery. For example, Mark stated it '*massively*' helped him to

have gone through the Royal Marines basic training. He said, *'We're a very small and elite group. And you have that (discipline) pounded into you all the time'* in training. Whilst in recovery, Mark discovered his previous ability of overcoming challenges during his basic training enabled him to approach rehabilitation as a continuation of his former military self—both physically and mentally:

When I was in hospital, that massively helped me. You know, I remember sitting there, thinking, the Royal Marines standards are up and they're so high. And just because I've been injured, it doesn't mean that I should drop my standards and feel sorry for myself. I'm still representing the Royal Marines because I was the first triple amputee and all that; media was kicking around then because of the interest. I, I knew I had to maintain that standard no matter what. (Mark)

Earning the Royal Marines green beret meant continuing the highest bodily standards, even after the level of injury Mark sustained. This standard persists as Hinojosa (2010, p. 183) asserts that 'discipline is found in action.' Mark continued to demonstrate his Marine discipline through the embodied action of rehabilitation and attributes the experience of his basic training to a successful recovery during this time of adapting to an injured body:

When I was, you know, sore and tired and bleeding and beat up and..just...you know, wanted to quit (..) That's what got me through it. (..) Probably, going through my rehab was the only thing that I can say was harder than going through Royal Marines training. And it is only by a tiny bit. (Mark)

Mark juxtaposed those two distinct experiences and yet, at the same time, stated that each experience—basic training and post-injury rehabilitation—required the same type of mental and physical strength to complete them.

Another participant, Jon, gave an example of remaining diligent in his bodily care, just as he did whilst serving in the armed forces. In his anthropological research with British Army infantry, Hockey (2016) refers to this form of bodily attentiveness as physical selfcare, which 'fostered a relative psychological ease' whilst in a military setting because it meant Hockey, as the researcher, was not a burden to those service personnel around him (p. 211). Jon compared tending to the

bodily wounds that he received during his Royal Marines basic training to caring for the leg wounds he received from the explosion. However, he noted the consequences are presently much harsher if he does not continuously care for his body:

[T]he discipline and the regime through team(work) that you bring into it... They become important in many ways. Just the idea of the way you look after yourself. So, looking after the wounds on your legs it's no different to looking after the blisters you get on your feet in training. Keeping yourself clean and hygienic becomes even more important when you're wrapped in plastic and sweating in (prosthetic) legs every day. (Jon)

And, according to Jon, it is not only the care of the exterior of his body, but caring for the internal is important as well:

Eating healthily... making sure you do eat, cuz it's really easy when your busy in work and all of that to forget doing that, but actually, in the past, doing that stuff just helps you be your best. (Jon)

He further explained that the difference in the 'before' and 'after' of wounding is not just about the wound itself, but that overexerting himself and neglecting his body would be negatively cyclical in nature. As a Royal Marine officer, he was quite fit and active, where he knew the penalty for running himself 'into the ground' in the past is vastly different than doing the same to his current body:

Now, um, it helps keep me out of hospital and that's the difference. So, I used to be able to run myself into the ground and I might need to go to bed after a few hard days whereas now if I run into myself into the ground, actually, I'm running myself into hospital. (Jon)

The reality is that illness is always there for Jon and he must adapt to a new way of living based, first and foremost, on his bodily needs. He can no longer choose when he 'listens' to his body because waiting or ignoring bodily issues means a visit to hospital.

Others spoke about the routine in a more mental and psychological fashion. For example, Lee stated that during rehabilitation at Headley Court, *'[T]hey try to get as much routine because, as military people, we tend to thrive with routine. I believe routine gets you through stuff anyway.'* Lee's statement encapsulates both a continuity of military routine and identity, which ensures those within rehabilitation experience 'a routinised, disciplined system' (Anderson, 2011, p. 137).

Dave, a double leg amputee, agreed that basic training and having a timetable, along with *'peak physical fitness'* at the time of injury, helped in his rehabilitation. Newlands (2013, p. 39) describes this as a 'routine existence regulated by a timetable' which becomes 'ingrained in memory'. Dave compares the rehabilitation and its schedule to his previous *'normal working day'* which he had in the Army after being injured:

Then you go into a rehabilitation routine which is very similar to a normal working day, in terms of timings and what you're expected to do, and the manner in which you're expected to conduct yourself. (Dave)

For Dave, the routine from both his military career and in rehabilitation continues onward after medical discharge, which he found beneficial:

[It] is familiar and easy to adhere to; having a prescriptive training programme throughout the day is very useful. Then as you move on, post-rehabilitation, into the real world, actually the discipline and the training that's been instilled throughout the course of your previous military career is still there and it still allows you to get up (..) and go and do what you need to do and have that discipline in the bits of your life which are still there. (Dave)

Continuity in both military discipline and routine were themes that arose for my participants. They spoke about the importance of both in their recovery. Other emergent themes were a change of perspective concerning their injury or injuries, friendship, and humour.

Change of perspective: Feeling sympathy for other injured service members

Another piece to participant recovery was being a witness to those fellow service personnel who experienced the types of injury where the recovery was impossible—or limited at best—and

enabled my participants to better understand their own bodily wounds. On occasion, participants revealed that they perceived themselves to be 'lucky' in comparison to other wounded service members. Participants explained that the complexity and types of injuries at Headley Court led to a form of wounding hierarchy (Deal, 2003), or a ranking of injury. They spoke of how they thought things could be poorer for them (pitting their own injury versus another person's injury) and why one type of injury is worse than another. MacLeish's (2016) ethnographic research findings are similar, as one of his participants:

'downplayed the severity of his own experience: he had been in combat, but only a bit; he had been hurt, but not nearly as badly as others he knew; he'd had it hard, but there was far worse out there' (p. 278).

Due to the military's hierarchical structuring (for example the classification of enlisted, non-commissioned officers, and officers), approaching the various forms of injury as a classification of 'better or worse' seems logical to service members in the rehabilitation setting.

The construction of a hierarchy of wounds within the rehabilitation establishment allowed service members to illuminate two things: being around others they deemed 'worse off' helped them put their own injury into perspective, and they can be more accepting of their particular physical wounds due to the aforementioned levels of compared severity (Mayhew, 2004, p. 191). One's perception of their injury can be just as important as the type of injury itself. For example, a recent preliminary study by Wilson et al. (2011) indicates that optimistic perceptions of one's injury can have positive physical effects for healing during convalescence. Conversely, it is suggested that people with depressive or anxiety symptoms experienced slower healing rates as well as increased problems with wound sites (Bosch, Engeland, Cacioppo, & Marucha, 2007). Other issues, such as stress, can induce higher levels of pain, complications post-surgery, and lengthier post-operative time in hospital (Mathews & Ridgeway, 1981; Johnston & Carpenter, 1980; Rao, et al., 2008). However, it is worth noting here that this information does not mean my participants are not

dissatisfied sometimes or do not get frustrated with bodily limitations. My participants do speak to those issues and they are addressed in the following chapter, which discusses injured bodies and disability.

It was during convalescence that many participants compared themselves to other wounded service personnel, discovering that they were able to view their injury in a more positive fashion (Carless & Douglas, 2017). As Andy stated:

[G]oing through that Headley Court process, with so many other lads, has massively helped me mentally as well to know that it's very hard for me to feel sorry for me-self when I know lads who've lost both legs and I've only lost one. Or lads who are triple amputees or lads who are blind, or lads who are brain damaged. So, it's, ... I don't tend to feel sorry for me-self too much. (Andy)

Participants claimed that being able to see and understand one could have more significant, debilitating injuries was a way for them to acknowledge the various types of wounds that exist for their fellow service members and this is why they were able to feel more optimistically about their own injuries.

This type of experience within rehabilitation encapsulates the dynamic of corporeal injury and psychosocial factors. The quote from Ken further highlights the categorisation of wounds found in the rehabilitation setting:

[W]e even had a pecking order! You know, a triple amputee "aces" a double amputee. (...) It was an unspoken pecking order, but we all got inspiration off each other. (Ken)

Tellingly, some participants mentioned that those with mental wounds were considered among the most disadvantaged. This opinion was not new in the military setting, as Anderson argues that a World War II report (The Tomlinson Report), 'made the distinction that had been established for some time that physical and mental disabilities were not synonymous' (2011, p. 89). My

participants re-evaluated their loss from a different perspective when they compared their physical injuries to their fellow service members' mental injuries.

Being in the rehabilitation setting meant that injured bodies were on display, especially during the morning routine of 'roll call', where, as in active duty situations, everyone is expected to be physically present. One participant addressed experiencing this particular military routine at the military rehabilitation centre, Headley Court:

[I]t was good in the way that you were with like-minded individuals although you could all have different injuries. So, you'd have complex spines, spine injury, [and] head injury. You would also sort of parade, or hobble, as it was, in a morning to roll call. So, you would see everybody, and it was a case of everybody would have 'injury envy', or sympathy. (Pav)

The idea of 'injury envy' is an interesting one. It alludes to perceptions of injury from those participants who are themselves within the confines of injury. Specifically, the participants were actively engaged with social comparison, using both an 'upward comparison' with a person perceived better off, achieving a more positive or optimistic view of injury (Festinger, 1954) as well as a 'downward comparison' with someone considered worse off, which can also produce encouraging view of one's situation (Wills, 1981). This behaviour can be viewed as a possible avoidance of being seen as a victim or being stigmatised because of the injury (Taylor, Wood, & Lichtman, 1993). Further, this comparison could ensure that my participants retain their sense of identity (as abled, military men) when they can differentiate themselves from those injuries—and people—they deem 'worse' (Stets & Burke, 2014).

When these service members have experienced a traumatic wound, they continue to incorporate an understanding of how much more difficult or painful recovery could be, as Pav further explained:

But, I know now, speaking to guys who'd lost limbs, they used to look at the Spines Course and think "Quaw [sic], I'm glad I've not got a spinal injury. Look at the pain they're in!" Then the Spines Course seeing the Head Injury patients,

thinking, "Poor guys, getting wheeled about in beds and stuff!" So, you could always feel sympathy for somebody else, which made your situation not as bad. (Pav)

In certain interviews, veterans explicitly stated that mental wounds were considered the worst type of wounds. Several specifically focussed on post-traumatic stress and knowing someone with it; they also stated they were grateful for not having it themselves. These opinions can be based within normative, masculinised behaviours of 'dominance, competitiveness, and self-reliance' (Finley, 2011, p. 81) and 'emotional control, physical ability, and self-discipline' (Hinojosa, 2010, p. 182). Post-traumatic stress can cause anger, violence, suicidal ideation, depression, and emotional withdrawal (Finley, 2011; Green, 2016), all which impact relationships and a career. Further, there is a stigma surrounding a diagnosis of post-traumatic stress following a deployment—during reintegration—that can cause alienation from others (Brewin, Garnett, & Andrews, 2011) and other societal problems, such as incarceration (Higate, 2013).

Only a couple of my participants indicated that they had post-traumatic stress and said it to me almost in passing. Having some of them talk about it in the rehabilitation setting helped me understand further this 'hierarchy' of wound types (Deal, 2003) and why a mental wound, a psychological trauma, was considered by the participants to be at the 'bottom'. Take the following quote, for example, about a placement in the Head Injuries Ward despite the participant not having any head wounds. Jon found it extremely difficult at the end of his rehabilitation day to be in amongst shared space in his ward hall:

[I]t's incredibly hard. You know there's [sic] moments when you just want to have a bit of time and space to yourself, draw the curtain around your bed and relax. And all of a sudden, you've just got a bloke appearing at the end of your bed, staring at you...um...who really doesn't have a clue what's going on and you can't get angry with them, because you know they don't have clue what's going on. But then having to deal with that...listening to some bloke screaming the house down. (..) All of that sort of stuff was not nice. (Jon)

Jon revealed to me how it affected his ability of focussing on his own rehabilitation, *'It's just very, very difficult when I was dealing with all my own shit at that time. So that was quite overwhelming.'*

Having a mental wound was classified by several of my participants as the worst infliction due to the perceived inability of improvement or progression with it. In other words, the participants explained a physical wound could be treated by something seen and felt (for example, a surgery, a prosthetic, or a brace) but the injury inside one's head was perceived as much more difficult—if possible—to treat, as the quote below suggests:

And he's not got any physical injuries. He's more the mental side of it. Which I think is a hundred times worse. (..) I'm glad that I haven't had any mental issues, like any PTSD or flashbacks cuz there's a lot of people down at Hasler who've been through that and they'll be in Hasler a long time, and that is so much worse than having a physical injury. Cuz a physical injury - you can just slap a brace on it and walk off. Whereas that side of things, is so much worse...So, I'm thankful I don't have any of that. (J.P.)

Even though J.P. revealed how difficult everyday life is for him due to pain, he states how simple it is to overcome his setback because he can 'just slap a brace on it'. At other points in J.P.'s narrative he revealed that the likelihood of having to amputate his lower leg is a reality in his future, his words here are quite telling with regards to what is deemed 'worse', which is mental scars or brain injuries from wartime experiences.

The severity of wounds was an informative theme revealed from the data. As I spoke with more participants, each one told me about their experiences of handling their injury but when encountering someone who had it 'worse', they were able to put their own injury into a different perspective. This new perspective did not apply to all of my participants, however, as two—A.D. and J.D.—have traumatic brain injuries, which will not improve and will continue to extremely limit their daily activities for the remainder of their lives.

Camaraderie: New friendships as 'cap badges go out the window'

Another example that participants gave about the benefits of rehabilitation was that it created space for having positive experiences, which were similar to those they had in their active duty military life. Some participants spoke about the significance of being around other injured people who understood the dynamics and ramifications of injury, what Hartley calls ‘sentiments of shared sacrifice’ that create ‘mutual bonds of friendship’ (2013, p. 189). A few participants mentioned practical jokes as a way of bonding with other wounded service personnel, which was similar to previous war veterans’ mischievousness (Anderson, 2011). Mark, a triple amputee, spoke about rehabilitation experiences that were a continuation of his military community—both inside and outside of the rehabilitation setting:

You know this is one of the things, again, I was grateful for about having suffered these injuries in the military, was you go to Headley Court and there are eighteen, nineteen men and women around you, going through the same thing. And you live with them, you really feel like you're on camp Monday to Friday. You know, morning to night. You're around those guys, which really, I think, helps get you through it. And that hit me when I came home. (..) [I]n Headley Court we had that massive advantage of intense rehab around the clock. You always around other people and we would do rehab in the day, and in the evenings, we'd get taken out and we'd go eat together. (Mark)

Social rehabilitation was a concept that was previously incorporated into the World War II recovery pathway; it ‘required the participation of others’ in the local community and ‘was specific to acceptance with injuries that caused disfigurement’ (Anderson, 2011, pp. 114-115). These social outings among local residents ensured the wounded service members did not experience this type of interaction alone. Many decades later, leaving Headley Court of an evening and going to a local pub, for example, created further bonding experiences for the injured service personnel but also enabled them to interact in civilian spaces. For brief periods of time, the injured would collectively step away from the rehabilitation setting and into society but return to Headley Court where, like themselves, everyone else around them was experiencing an ‘abnormal normality’ (Hollander & Gill, 2014, p. 225).

Mark specifically said that he was not treated differently in the military rehabilitation setting but that those recovering from their wounds would find ways to interact with each other in a unique fashion:

The brilliant thing about the military is that they don't treat me any different. You know? Like, when we were in rehab, if you saw some of the stuff we got up to, if it happened in the civilian hospital, I wouldn't say you'd get sent to jail, but you'd certainly be reprimanded for bullying. It's a different mentality in the military. (Mark)

He gave further examples of the types of military mischief that occurred at Headley Court whilst he was there, enjoying the act of telling it to me almost as if he were reliving it. He spoke with a smile as he said, 'so you know, guys would steal limbs' (prosthetics). This behaviour is supported by Hinojosa's US research, wherein service members traditionally 'threw jibes at personnel in other branches' as part of 'inter-branch rivalry' and 'a way to bond with fellow branch members' (2010, p. 185). Mark continued with defining it all as '*banter*' and that the pranks were how they '*got through it*':

I remember once I was with a guy with both legs missing who...had lost 80% of his sight and the lads took moisturiser cream and filled his (prosthetic) sockets up and he couldn't see it. Or we'd put the fish tank in the lift so guys that are paralysed couldn't get anywhere in rehab cuz the lifts were full of fish tanks and plants. You know, stuff that civilians would go crazy about was just banter to us, what got us through it. And it was all done in good humour. So that's what I loved about being in that military setting. (Mark)

This extension of the military was enacted corporeally as illustrated by their '*banter*' (or shenanigans) and also through a continuation of their identity, which included approaching issues with humour, or '*black humour*' as it can be referred to in the military (Wool, 2015, p. 38) and '*coarse jokes*' (Caddick, 2018, p. 6). The service members knew they could behave with each other in such a fashion as they are part of a '*specific discourse community*' (Morris, 1997), which would most likely be unwelcome (and unexpected) in a civilian rehabilitation setting. J.P.'s experience of military antics, to a civilian ear, could sound like an attack on him and his personal space, but that

was not his message; he told me that this behaviour is positive and helpful during recovery. As he was in his room, a fellow Royal Marine who was also in recovering from a leg injury appeared and:

Bloody just came wheelchairing in and threw one crutch out the uh, fire exit and the other one down the corridor! So, I was like 'Uh, what should I do? I have to hop, hop to go get me crutches now!' but he found that hilarious.... (J.P.)

J.P.'s story about his crutches being taken might seem like a harsh interaction but is actually more of a revelation about the type of bonding and camaraderie one finds in the military community, especially following a disabling injury (Kinder, 2015). Service members joke and tease each other, especially when experiences are stressful and relatively ineffable to a civilian. For example, MacLeish states, 'Soldiers say that a body that has been blown up looks like spaghetti' (2013, p. 86) and he highlights the experience of a female US service member who vomited when dealing with bodies destroyed by an IED. Her colleagues later gave her a plate of spaghetti in the dining hall as a joke 'to let her know it was okay' as 'the plate of pasta closes the gesture and gets everything moving in the right direction again' (MacLeish, 2013, p. 86). The gesture is an attempt at camaraderie, inclusive of black humour, all in the aim of moving forward to grasp the seeming incomprehensibility of war's psycho-somatic imprint upon those who live through it.

J.P. further expressed behaving in this humorous manner is a positive form of rehabilitation and coping as it helps keep his mood optimistic (Zillman, Rockwell, Schweitzer, & Sundar, 1993). There were behavioural parameters amongst those in rehabilitation, however, as J.P. made clear to me. For example, as a Royal Marine, he knew he could not interact that way with a service member from a military branch outside of the Royal Marines. He also mentioned that one cannot 'flash', or verbally argue, with whomever is doing the antics because that is part of the cycle. One must 'take it' and wait for an opportunity for reciprocation:

It were [sic] all done in good fun and it's good banter. Otherwise, it would be a very miserable place. (..) I don't think you'd do it to any-- like, someone you'd just, just met who were in the Navy, or Paras, or somebody. You wouldn't just go and kick his crutch out. (..) I think that might be bit too far. But because we

were both Marines and ... you can't flash. Like, you can't just argue. You've just got to take as it is...like, as a joke...and try to get him back later. Otherwise you'd just be a very depressed. (..) You'd just be absolutely miserable, depressed. That bit of banter, just try and make it into a bit of a joke, or try and laugh it off, rather than just ...just cry every night. (J.P.)

J.P.'s statement that one could either joke their way through or 'cry every night' seemed as though he was, in military manner, dismissing the reality that one could joke through the day and also be sad or depressed at night. Several participants presented their narrations this way—their telling was both a *rejection* and a *revealing* of emotions normally held at bay within military settings due to expected heteronormative masculinity (Higate, 2003; MacLeish, 2013; Carless & Douglas, 2017). As Carless and Douglas indicate, veterans 'may feel pressured to confirm to a cultural script of still being mentally tough and physically strong, while living (and often re-living) a personal embodied story of vulnerability, weakness, and shame' (2017, p. 375).

Even so, the closeness that service members have in rehabilitation centres are where, as Wool (2015) states, 'intense and intimate socialities [sic] link soldiers' (p. 46). This linkage is a small but vital piece of my participants' stories, as it illuminates the importance of social interactions and shared sufferings mentally and physically. The ability of allowing the 'interfusion' (Kleinman, 1989, p. 359) of mutual experiences continues to bind those who have a generally collective, common past. In other words, having the similar backgrounds of basic training, a military career, deployments, plus an injury enables the wounded service personnel to form new bonds with those who are, initially, strangers in the military rehabilitation setting. As Andy stated, '*I think at Headley Court [it] worked really well in that sense where you're surrounded by your friends*' and also that he '*always found that a lot of the Marine lads, we all kind of stuck together, and, it was almost a competition to, kind of, "rehab better"*'. Andy mentioned that a friendly sense of competition between the different military branches was an incentive to do better or achieve more during rehabilitation (Hinojosa, 2010). No one else specifically mentioned this type of competitive approach so it is an interesting and revealing finding of this research. Further, it could offer support

as to why sport is popular once medically discharged—specifically the Invictus (United Kingdom) and Wounded Warrior (USA) games.

The idea of friendship was also indicated by Lee, who explicitly stated:

The Royal Marines is quite small. (...) If someone was in the Marines, if I don't know them personally, I will absolutely 100% know someone very well who knows them very well. We're always only one person away from each other. The guys that are at Headley Court, I know of or knew them, anyway.
(Lee)

This interconnectivity of being 'only one person away from each other' meant that it was a very small community, ensuring there are no real strangers amongst the Royal Marines. As Lee stated the level of 'knowing' is extremely high making them feel quite assured in the type of bonds and camaraderie that can be found in small groups. Other participants spoke of developing new friendships whilst in recovery for their wounds based upon shared experiences, as Dickson et al. stated, '[T]hey share a sense of belonging with other people who have survived life trauma or tragedy' (2008, p. 414).

Paul fondly refers to the cross-service connections that took place in rehabilitation. He teased me (in his military humour), saying that his new 'best pals' are among those whom he would not have considered befriending prior to his injury due to inter-branch rivalry (Hinojosa, 2010), but that being wounded is what ultimately binds them together:

The cap badges go out the window then. You're all sort of, like, one and that was ace because some of my best pals now are paratroopers, army engineers, you know, even stinking, bloody Navy. Um, and it's just the camaraderie. Cuz say, being in the military binds you tightly anyway. Being in the Marines binds you tighter than that. Being an injured soldier binds you tighter than that. Being an injured Marine tighter...it, it just like these little circles. And um, it was awesome. (Paul)

For Paul, it was 'ace' and 'awesome' to have the camaraderie at Headley Court, or as Wool (2017) suggests, the injured 'skip[ped] over the incremental steps of getting to know one another in favour

of profound identification and affiliation' with regards to their injuries, how they were inflicted, and the impact the wounds have on their life (p. 85). Whilst this can be found generically speaking within the armed forces (Hinojosa, 2010), this deep connection of injury bonds them even closer.

Dave, a Royal Engineer, who explained his experience of hospitalisation and rehabilitation following the loss of his legs whilst on his first deployment to Afghanistan, also expresses this sentiment of togetherness and solidarity. The rehabilitative realm is more than just the physical space, it is psychosocial. This perception of rehabilitation is about being surrounded by others who 'share an experience of fragmentation' (Wool, 2015, p. 191) that will not be found in everyday, post-rehabilitation life. This 'fragmentation' can be both literally, because of their bodily injuries, as well as figuratively if they experience the fragmentation of their identity and sense of self. I asked Dave if he found the opportunity to connect or befriend others during rehabilitation. He told me about both the experience at Birmingham as well as at Headley Court:

Absolutely! Yeah, from 'Day 1'. There's [sic] not many 'single man' rooms in the hospital in Birmingham. There are a couple, but I was fortunate enough to not be in one. I was in a four-man ward in hospital. In that room, initially, there were two other bilateral amputees in the room and one guy who'd been blown up but wasn't an amputee. (...) There were people in very similar situations from Day One. You become very close over that short space of time in a very enclosed hospital room. [A]nd then we did all of our rehab together. (...) We've made some very good friendships over the course of the years and these are some of my closest friends now, despite never seeing their feet or anything like that. So, there was a very good opportunity to become close to people. (Dave)

The military humour surfaced as Dave was telling me that he befriended wounded ex-service members '*despite never seeing their feet*'. 'Comedy', according to Morris (1997), 'seems to be an enduring response to the dehumanizing powers of pain and suffering' (p. 32). As is seen from other participants' rehabilitation narratives, humour was (and is) key to healing and moving forward in their life.

I enquired if the experience was different between hospital and the Headley Court rehabilitation centre for Dave and he responded:

So, you have the guys who initially you go through hospital with, and then at Headley Court, everyone does all of their rehabilitation together within the complex trauma groups, unless it's physically impossible for them to do it. (..) So you're constantly meeting new people who are coming back through on a different admission, perhaps, that you might not have seen before. It's very much a group-orientated environment, so you get to meet an awful lot of people and forge these relationships over the course of time. (Dave)

Finding humour in everyday occurrences and developing friendships with the fellow wounded service members were positive and important aspects to my participants' recovery.

Conclusion

This chapter has illuminated the stories of my participants and their injuries. In their own words, their stories reveal the moments leading up to and including when they were injured, either in the United Kingdom or on an operational deployment. They spoke about rehabilitation and ways they found it beneficial. The stories highlight the importance of togetherness during recovery as well as needing humour during recuperation. An interesting finding of my research was the discovery of a form of hierarchy in the rehabilitation setting; seeing those who 'had it worse' made my participants feel like they were 'better off' than fellow injured service personnel. Another important finding was the concept of particular service members who 'rehab better'. The themes discussed in this chapter were of a military continuity (found in the rehabilitation setting), feelings of camaraderie with fellow wounded veterans, and a new perspective about their own injuries.

Chapter 6: Transition Narratives: Experiences of Military Exit due to Medical Discharge

Introduction

The previous chapter focussed on the narratives of my participants' injuries and their experiences of rehabilitation. The type and severity of their injuries, as well as how well they were rehabilitated, impacted their military-to-civilian transition. We turn now to the preparation for, and experience of, medical discharge from the UK Armed Forces. Then the narratives about participant military to civilian transitions will be addressed. Lastly, participants shared the ways in which they attempted to find agency and control when dealing with their post-injury bodies. The experience of medical discharge is a temporal point representing a major critical life event, which holds great emotional and social significance in participant autobiographical narratives. This event is something that they physically build up to during rehabilitation, prepare for, and experience within a definite temporal and geographical space.

Several participants spoke about a fairly fluid, planned process of leaving military service. Other narratives concerning the discharge and ensuing transition were of shock, grief, and loss. Some spoke of the experience as a 'betwixt and between', as it was a combination of factors. I am using the term 'transition' as defined by Herman and Yarwood (2015), wherein it is 'positioned as an on-going spatial process rather than a singular event that marks a disjuncture between the different lives lived in the military and civilian spaces' that might never be completed (p. 41). The implication that it is possible for transition to never be complete allows for a 'blurry', indistinct space between what was, what is, and what may be. Furthermore, I incorporate the life course perspective, which studies 'the interaction between individual lives and social change', as put forth

by Brittain and Green (2012), 'The life course perspective sees human beings as capable of making choices and constructing their own life journeys, within systems of opportunities and constraints' (p. 253). Brittain and Green's research dealt with service personnel's transition after enduring 'life-changing trauma and [were], through the use of sport, negotiating their post-injury status and place within their society' (2012, p. 253). By framing transition as an (in)complete process that can be agentic, with systemic 'opportunities and constraints', it enables the narratives of my participants to be understood from their perspective.

An overarching theme was one of trying to find agency within the systems of care—of seeking control and certainty within an uncertain situation. When describing their post-discharge experiences, participants spoke of seeing to their own physical and mental care once they were released from their respective branch of the armed forces. They addressed the medical transfer from the military to the care of the National Health Service (NHS) and the difficulties they experienced. Notably, they talked about the pain medication experience: facing addiction and discontinuing use because they would rather have pain than experience a lack of bodily control. These examples are a way for participants to 'control their stories' and 'asserting their agency' (Berghs, 2008, p. 82) in the 'shift from object of power [the nation-state] to the subject of power' (Schrader, 2019, p. 73). The ability to gain control of one's physical self *and* one's narrative after military exit was vital for the participants who spoke about corporeal post-injury issues.

Medical discharge

A synopsis of medical discharge

Medical discharges from the Armed Forces are the 'result of specialists (medical, occupational, psychological, personnel, etc [sic]) coming to the conclusion that an individual is suffering from a medical condition that pre-empts their continued service' (Ministry of Defence: Defence Statistics (Health), 2014). In other words, if they are no longer physically or mentally

capable of doing their job, the service member will go through rehabilitation and recovery to prepare them to depart military service. The process of the medical discharge includes medical examination and 'grading', which determines the service member's trajectory. In the worst-case scenario where the service member has no chance of full physical recovery, they are recommended for a medical discharge. Before the discharge occurs, however, the service member is 'downgraded' to 'allow for treatment, recovery and rehabilitation' (Ministry of Defence Statistics Health, 2018, p. 2). Two of my participants, Dave and Lee, for example, were downgraded and returned to duty, working in Personnel Recovery Units (PRUs) until their medical discharge from the Army and Royal Marines, respectively. J.D., too, was downgraded and continued serving in a different capacity. Whilst these examples are not in the majority with regard to the participants, this action allowed the three participants to continue working for the armed forces whilst finishing their military careers prior to medical discharge.²⁶

To further highlight aspects of the military's medical discharge route, I have included information from a Ministry of Defence report. The following is from the 'Annual Medical Discharges in the UK Regular Armed Forces' (Ministry of Defence, 2017) and summarises the military's approach to defining and handling injured service personnel:

Service personnel with medical conditions or fitness issues which affect their ability to perform their duties will generally be referred to a medical board for a medical examination and review of their medical grading. In clear cut cases where the individual's fitness falls below the Service employment and retention standards²⁷ the board will recommend a medical discharge. In many cases however, the patient will first be downgraded, to allow for treatment, recovery and rehabilitation. For personnel who do not make a total recovery, the board may recommend the patient is retained as permanently downgraded with limited duties, or they may recommend a medical discharge. The recommendation is then forwarded to personnel administration units or an employment board for ratification or decision and action.

²⁶ Another participant, J.D., was close to finishing his twenty years of service wherein he would be eligible for his full pension, and so he returned to finish out his final years before retiring.

²⁷ 'As laid down in JSP 346 and/or the single Services retention standards for their career group.'

The medical form, 'FMed 23', is in Appendix E. As part of a larger document, this form outlines the guidance given to medical officers who decide the fate of the wounded, injured, and sick (WIS) service personnel (Ministry of Defence, 2018; Ministry of Defence, 2017). It serves as a record of the medical board's findings, the decision-making process, as well as documenting items, such as 'type of enlistment', 'Date (of Principal and other conditions)', and 'Place of origin' (where the injury occurred, such as Iraq) (Ministry of Defence, 2018, pp. App 1-2).

Preparation

During the preparation for medical discharge, which is a time of transitioning from the military to the civilian world, service members are offered opportunities, such as employment courses, assistance with their CVs, and adaptive sport activities. Resettlement courses are offered to exiting service personnel during rehabilitation and after discharge in recovery centres like Hasler. 'Resettlement' is a term used to describe the military-to-civilian transition. In reality, resettlement aims to incorporate a *reintegration* into the civilian world of jobs, mortgages, and other routine activities, as well as a *reconciliation* of a new way of being in the world—one of being a wounded veteran, surrounded not just by civilians, but able-bodied people. For example, the transitioning service member might take courses on how to write a resume for future employment, manage finances, paying bills, or preparing meals, as they may not have performed these mundane tasks prior to military service.

Throughout rehabilitation and resettlement, the experiences of WIS service members are, at first glance, subject to a homogenous and institutional approach of physical rehabilitation along with the offer of resettlement courses, which serve as preparation for post-military employment. In reality, each injury receives special, individualised care during their rehabilitation at Headley Court and this approach continues for some in recovery centres. As of 2014, service members can further their recovery pathway at the aforementioned Hasler NSRC Endeavour Centre. This physical location exists to either return the service member to duty or, in preparation for resettlement,

rehabilitate the WIS service member for medical discharge and transition to the civilian realm. Hasler's objective is 'improving personal independence, raising morale and enjoying the camaraderie of fellow servicemen and veterans to help rebuild their lives' (Ministry of Defence, 2014). This particular centre is similar to Headley Court, wherein the WIS service personnel can stay through the week whilst they receive various forms of rehabilitation and resettlement training; they are also free to return home each weekend. Hasler NSRC is a joint effort between the military and a 'third sector' partner²⁸, the military charity Help for Heroes²⁹ (Ministry of Defence, 2014), and consists of multiple special-purpose buildings, such as the Endeavour Centre.

The Endeavour Centre and lodgings were purpose-built specifically for WIS recovery and opened in 2014. The Centre includes a gymnasium, pool, sauna, and, for social rehabilitation, a lounge area and small café. Accessibility is an intentional feature of Hasler NSRC's design and therefore lodging is located nearby; it includes a lounge, laundry facilities, hotel-like rooms, and a roof top lounge area.³⁰ To illustrate this space, I include pictures of my site visit to the Endeavour Centre, which is where WIS service personnel are physically rehabilitated at Hasler NSRC (see Appendix F). The photos demonstrate what a service member would see each day whilst they recuperate and recover. In this particular physical location, military personnel and military charity employees work alongside the WIS in their recovery trajectory. As the website states, 'Hasler Naval Service Recovery Centre is designed to professionally command, co-ordinate and administer a bespoke recovery pathway for each assigned rank and to provide effective assistance and support to them and their families.'³¹ For example, Help for Heroes runs a programme entitled 'Pathfinder'

²⁸ Military charities are called the 'third sector' in the United Kingdom.

²⁹ Help for Heroes has five recovery centres located throughout England and Wales: Phoenix House Recovery Centre (Catterick), Chavasse VC House Recovery Centre (Colchester), Tedworth House Recovery Centre (Tidworth), The Naval Service Recovery Centre at HMS Drake, (Plymouth), and Community Recovery office in Treforest (Pontypridd, Wales).

³⁰ I was told that there are no televisions in the individual rooms in order to encourage social engagement amongst the WIS at Hasler.

³¹ From: www.royalnavy.mod.uk/our-organisation/bases-and-stations/naval-base/devonport/hasler-recovery-centre

at their Centres, which assists with military-to-civilian transition (Help for Heroes, n.d.), which two of my participants mentioned undertaking at the Tedworth House Recovery Centre.

Several participants spoke about the Recovery Centres' importance to them. As with Hartley's (2013) research that focussed on disabled former militia in a Lebanese hospital, the Help for Heroes Recovery Centres create a 'safe' space within which stories of heroism and sacrifice could be told and where the residents did not have to justify their past actions' (p. 191). In some respects, those veterans who frequent the Recovery Centres are replacing one institution with another: the formal, organised Armed Forces institution with the military charity institution, which is elective and rehabilitative, but still creates a physical surrounding that has apparent military-esque overtones. It is not uncommon to see an occasional uniformed, active duty service personnel in the Recovery Centres. In the Hasler Recovery Centre, it is on a Royal Navy base and so the Centre is completely surrounded by service members. Like other military spaces, the Centres exemplify social spaces and places where those present will understand that others around them will automatically 'know' what has happened to them (the veterans) and why they are there. Participants mentioned a preference for being around others who understood their military history, because they felt civilians would not understand.

The Recovery Centres serve as an area where, even though there are some civilians working in the space, a former service member can be in a controlled, post-military environment—a place for *'meeting other people in the same position'*, one participant (Colin) told me. As Frank (1995) states, a 'solution was being kept apart from a world that could not, and would not, understand' (p. 107). These military charity organisation spaces offered just such a 'solution' my participants, as 'beneficiaries'³² feel surrounded—and supported—by newly acquired 'mates' in much the same way as they did in their previous Headley Court rehabilitation experiences.

³² The term that Help for Heroes uses when referring to those who seek their services.

Presentation to the medical board

As demonstrated in participants' quotes below, the actual military discharge event is one of formalities and protocol wherein the service member must present themselves to a medical board for judgment. As described to me the participants enter, wearing their 'best uniform', they were 'marched in', presented to a medical review board. Participants were then given the board's decision as to whether they may be retained through an extension (which occurs if they are continuing rehabilitation) or if they were to be immediately discharged. Through this procedure, it is evident that the 'military owns the process' (Lester, 2015) by deciding when, where, and how a person is institutionally expelled.

Also, the presentation of the service person in their uniform (that might not fit) on a body (that might not be capable of literally 'marching') mandates a continuity of a public, masculinised, and embodied military performance (Lande, 2007; Csordas, 1993; Basham, 2013; Woodward & Jenkins, 2011). This performance was previously achieved through well-rehearsed martial actions, which create a *uniform* and *uniformed* body, which is from an 'intensive training' that generates a 'particular kind of corporeal engagement with the world' (Hockey, 2013, p. 95) and also with those military service personnel surrounding them. In other words, the wearing of the physical uniform, marching in, and presenting oneself before the medical board officers is an extension of performed military expectations—not just for these injured service members, but also for the medical board, who are sitting in judgment. They must accomplish a final 'act' (Goffman, 1959), or embodied military performance, before permanent dismissal from the ranks. As J.P. explained:

It's, it's very, very formal; you're in your best uniform. You march in and sit down and... there's like maybe 4 or 5 blokes, sat at a big table across from ya. And you'll sit down. They'll talk you through everything and all your medical records and they'll say what the best course of action is... And then at that stage, you can say 'Can I get a three-month extension?' or whatever... And then they just said, 'No.' (J.P.)

As we will see below, J.P.'s particular discharge experience was one of disbelief and unpreparedness. He spoke about how surprised he was that he had not receive the requested

extension of three months to further his rehabilitation. Many times, the WIS service personnel are still in recovery and desire to remain in the military until they have completed all possible rehabilitation (Messinger, 2010). Moving out of—and away from—the familiar military environment and into the (seemingly) unfamiliar civilian space was a transition some participants felt they were ill-prepared for upon being medically discharged. This sentiment was especially apparent if the injured veteran required continued physical care and oversight (which would be transferred to the National Health Service). Until this time of military exit many were focused on regaining control of their injured body.

Andy also spoke about the physical act of the medical discharge board experience. Andy's narrative of situational acceptance whilst being presented to the medical board quickly turned into heartbreak and defiance. Like J.P., Andy was explicit in giving me a representation of military performance, judgment, and expectations:

But then the one moment which kind of broke me heart a little bit was when I went in for the actual medical discharge and I think, you know, you wear your uniform and you get marched in, and you have all these officers sitting behind the table. (Andy)

Andy was the only participant who disclosed that a service member must submit a personal statement in order to be medically discharged.³³ This is a 'completed FMed24 (personal statement of the history from the patient's perspective)'. Here he explains that not only is his statement in a physical document, he also had to verbally state his request to be discharged:

And in my personal statement, I said, you know, 'I respectfully request to be medically discharged. I think it's better for myself and for the Marines.' And the officer said, 'Yeah, we think you're being, kind of, mature and you're correct

³³ 'A personal statement from the Soldier / Officer is required for all cases referred to the AEB secretariat along with supporting statements. The appropriate MS Branch will be responsible for aiding in submitting all paperwork described in Appendix 25 Para 5 to the AEB Secretary prior to the commencement of the AEB.' This is a 'personal statement of the history from the patient's perspective.' From: assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/472047/2015_0429_FOI03539_PAP10_Version_3_PDF_Final_SO2_Cap_Dev-U.pdf

in what you're saying. And we don't think you are actually fit enough to stay in the Royal Marines.' (Andy)

At this point in the story, despite being stood in front of the board with an amputated lower limb, Andy's military demeanour appeared as he told me about his reaction in the moment because his face became determined, there was an intensity in his voice, and his body became more rigid:

And it was when I heard someone say, 'You're not fit enough' for a second, for split second, I felt like saying, 'Actually, you know, I take that back.' You know, 'I'll prove to ya that I am.' You know, 'I do want to stay in.' I felt really passionate about it then. But, again, that was just in, kind of, the heat of the moment, having someone say to me I'm not fit enough for it. But that was the only moment, really, I, I started...you know, I knew it was for the right thing. (Andy)

This momentary resurgence of Andy's desire to be in control during the discharge process, of being defiant about allowing someone else to decide his future in 'the heat of the moment', was indicative of his desire to own the process. He still wanted to be the one to choose his future, not have it be decided by the medical board officers.

'Shock to the system'

J.P.'s narration of his medical discharge indicated it was difficult for him to process in the moment, even though he indicated the discharge was highly likely to happen the day he was presented to the medical board. This experience added to the difficulties of J.P.'s transition. I leave in J.P.'s narrative hesitations because it demonstrates the difficulty in his telling me what happened. I was one of the few civilians that J.P. shared this story with. Eventually labelling it a '*a shock to the system*', he expressed the experience as such:

I went down to Portsmouth for my discharge, yeah. Came as a bit of a shock, as well, cuz you never really expect it to, to happen. Cuz, I'd just got this new, it's like an insole for your boot, but I could wear...I wouldn't have to wear the brace. It'd just be your normal-sized boots with an insole, with a wedge in it...and you could try walking with that. (J.P.)

J.P.'s injury was an IED-damaged left leg. Whilst he did not lose his foot, there were problems with walking on it every day. J.P. tried different therapeutic approaches, as advised by his rehabilitation team. Due to the latest recommendation put forth by his team, he requested a few more months of rehabilitation for his foot prior to a formal discharge. He continued, explaining that since he recently received the new orthotic treatment, he wanted to remain at Hasler until he had grown accustomed to using it:

So, I was just getting to grips with that, so I was asking for, like, a 3-month extension and they were like "No. You're going." So...I hadn't really prepared....well, I knew it was coming but I wasn't expecting it to come like then. So, I was like, "Oh. I'm not in the military anymore." And it came over bit of a "Uuhhfff! Bloody Hell!" That came as a bit of a... bit of a shock...that uh, I was a civilian. I mean, going outside, it wasn't like, scary becoming a civilian...inside... Financially, I'm, I'm fine. Don't need to work. But the fact that I wasn't in the military anymore was just, like, I'd been in the military for so long I was just like "Oh my god...!" It was just a bit of a, bit of a shock that I was... not a Marine anymore...if that makes sense?... You can stagger outside and weep onto each other's shoulders...It's not...It's too bad...but still.... it's still a shock to the system. (J.P.)

J.P. clearly was ill prepared for the abrupt transition from the military world to civilian life. As mentioned above, he was experiencing a 'fear of re-entry' (Frank, 1995, p. 107), where the entry into the civilian world was through a very immediate ending to his military world—the only world he had known since being a teenager. Despite saying it was not '*scary becoming a civilian*' he described being in '*for so long*' that it was a shock he was '*not a Marine anymore*'. J.P., like others who narrated an abrupt transition, was clearly experiencing 'reverse culture shock' (Bergman, Burdett, & Greenberg, 2014). J.P. seemingly joked that one could '*stagger outside and weep onto each other's shoulders*' because, in that moment, those being medically discharged were all in it together. The reality is that once the service members are discharged, they are no longer continually surrounded by their military community anymore. Due to this rupture of the 'taken-for-granted-ness' of military life and its bonds, they must 're-create meaning' (Hale, 2008, p. 308). The participants' experiences of not being around those people who understand are why the

Recovery Centres continue playing an important role for those whom have been 'transitioned out' of the military.

One issue my participants contend with is having been part of a 'greedy institution', defined by Coser (1974, pp. 4-6) as an organisation that will 'make total claims on their members (and) they seek exclusive and undivided loyalty'. Segal (1986) asserts that the military is just such an institution, wherein she states that the risk of being injured or killed is 'an obvious aspect of the institution's demands' and that placing the service members 'at such physical risk is perhaps the greediest aspect of all' (p. 16). The struggle during the transition is that '[t]he military was a world with an inside and outside, and ways of being in or out of it' states MacLeish (2013, p. 44), which 'points to an awareness of the military's enclosing and totalizing [sic] nature.' As seen below, it was evident in several participants' narratives that there was a sense of having given to the 'greedy institution' only to be betrayed by it due to the medical discharge.

During the preparation for medical discharge, much is unknown for my participants. They are navigating through 'wreckage' of their bodies and careers, so felt uncertainty in the lack of control over their lives. After the dual disruption my participants experienced (to both body and biography), they can attempt 'to connect the previous identity with the new identity that has arisen during the process of biographical disruption' (Pranka, 2018, p. 5) so we see my participants assert their 'military self' with choosing when—and of what—to be in control, while simultaneously experiencing a lack of control in their discharge.

Additionally, some found themselves acknowledging a lack of control over their future due to the impending discharge. This sense of 'double' disruption to their life trajectory—one of body plus one of career—surfaced throughout multiple participants' narratives. For some, they found small ways of reclaiming control after their discharge, despite the lack of agency in the medical decision-making process. This type of disruption, as Williams (2000) asserts, 'is perhaps most keenly felt among the privileged rather than disadvantaged segments of society' (p. 50). In other

words, because the service members were young, fit, and independent prior to their injury, then they would 'feel' the disruption more profoundly than someone who might be aged or already struggling with other health issues.

Continuation of military identity

As previously mentioned, narratives dealing with identity typically have a sense of temporal coherence in order to make sense to both the teller and the listener (Squire, et al., 2015). Autobiographical reasoning, or how one links life events across time to make sense of the past and future, gives a form of fluidity to identity in life narratives (Habermas & Kober, 2015; Habermas & Bluck, 2000). Pasupathi (2015, p. 166) suggests that identity is 'a problem to be resolved' continuously in one's life. This sense of needing to 'resolve' an identity is apparent in other veteran narratives describing who they are now due to military experiences. Veterans' current identity *now* is based upon what occurred to their body '*there and then*'; this is especially prevalent if their body was injured in combat (Wool, 2013, p. 415). As Squire et al. indicate, 'the body asserts itself, since it is central to lived experience and cannot be narrated away' (2015, p. 81). During the medical discharge and military-to-civilian transition, who they are and who they were has been impacted but what the body can—or cannot—do now. It cannot function at the level required by the Armed Forces, hence the medical discharge.

Whilst time had passed between injury and discharge, the struggle continued after military exit to reintegrate into the civilian world. As Mobbs and Bonanno (2018) state, '[T]he transition into and then back out of military life is complex and multifaceted' (p. 142). Before participants' injuries, they viewed and understood themselves as defined by a military perspective: physically fit, capable of protecting others, placing themselves in danger, and 'part of the elite'. Jelušič (2003) labels this idea the 'military mind', which is directly linked to the 'distinct goal, mission, and methods of executing a particular mission' (p. 356). Jolly (1996) states the armed forces create a

military persona, which is difficult to 'discard [it] and the build upon its foundation a new social identity' because there is 'no one to help the leaver' accomplish this task (p. 4). Additionally, Bourdieu's 'embodied history', or military habitus, further guides understanding the longevity of a military identity (1990, p. 52). Maringira et al. (2105) refer to this as a 'soldierly habitus', which is 'not temporal but a lasting state-of-being fostered by how they had been inculcated with a military ethos and military practices' (pp. 31-32). These collective tenets are exhibited in several participant quotes below.

For service leavers who are physically fit, options of continuing in a military-like line of work are private security contracting or other 'corporeal careers' (e.g. firefighters, police, paramedics) (Higate, 2013; Shafer, Sutter, & Gibbons, 2015), which allow former service members the opportunity to transfer their particular skillset into alternative employment. If the ex-service member experienced traumatic injuries and was medically discharged, however, life is more challenging as they look to a future without a fully functioning body (Carless & Douglas, 2017; Cogan, Haines, & Devore, 2019). Jolly's research found that service in the military gives 'stability, self-confidence, a sense of identity and a feeling of belonging' but makes medical discharge difficult, as 'leaving was almost unbearably hard' and one can 'still feel bereft' many years later (1996, p. 26). Research with veterans demonstrated that even though they are no longer in the armed forces, they still strongly identify with their military history (de Medeiros & Rubenstein, 2016; Bulmer & Eichler, 2017; Cooper, et al., 2017). As Woodward and Jenkins (2011) describe 'individual military identities as rooted in "doing" rather than any essential categories of "being"' (p.256), which will we see in participant recovery narratives and later in chapter eight.

Disruption

Experiencing a large adjustment in life can be unsettling for anyone. For example, changing jobs, moving to a new house, or having children are all changes that can 'disrupt' or cause slight

disorder in anyone's life. These types of fluctuations in life are occasionally of our own choosing, sometimes temporary, and can be perceived positively. However, other examples of these 'biographical disruptions' (Bury, 1982) can be ominous, such as a loved one's unexpected death, receiving a diagnosis of a chronic illness, or divorcing. Bury states illness creates differing experiences of 'pain and suffering' as well as differences in 'structural constraints over the ability to adapt' (1982, p. 178). Adaptation and agency are the ways in which participants are able to overcome the lack of knowing in the instance of a military injury—knowing the future, knowing an injured body, or knowing what physical limitations or pain to expect. 'Associated problems of uncertainty', argues Williams, are 'diagnostic uncertainty, symptomatic uncertainty and trajectory uncertainty' (2000, p. 44).

One answer begets another question—the injured service member 'knows' what is wrong now, but it raises the question of uncertainty about their future, which, as Bury (1982) suggests, could be 'a future of growing dependency and invalidity' (p. 173). Further, 'medical and scientific uncertainty itself shatters certitude' (Carricaburu & Pierret, 2004, p. 292), which creates disruption in a life narrative. This type of 'narrative wreckage' is caused due to a lost 'sense of temporality', wherein the 'present is not what the past was supposed to lead up to, and the future is scarcely thinkable' (Frank, 1995, p. 55). People use the 'memory of their previous environment as a frame of reference. Normally, this will be only as a temporary measure while they adjust to the new reality, but for people in an otherwise intolerable situation, it may persist indefinitely' (Jolly, 1996, p. 46). The duality of dealing with a broken body and an unknown discharge process—or what might happen afterward—leaves some injured service personnel in a 'critical situation' (Giddens, 1979), or as Wool (2015) succinctly states, 'the unstable bodies and looming infections that keep soldiers' futures unknowable' (p. 160).

Narratives of military exit transitions

When I asked participants about the military-to-civilian transition after their military discharge, there were two dominant narratives that arose: an easy, expected discharge or an emotional—sometimes shocking—discharge. A third narrative, which was less pronounced throughout participant interviews, was one of a ‘betwixt and between’ of the space between holding on and letting go (Dima & Skehill, 2011; Bridges, 2009). It is evident in some participant narratives that they struggled with the abrupt finality of this change because, pre-injury, they viewed themselves as someone with a military career in their future. It is understandable given that many had spent more than a decade in military service. Others, however, had served a ‘full career’ of twenty or more years and still expressed the same sort of shock and anger at the career loss as the younger participants.

Planned transitions

Four of my participants described a relatively fluid transition between anticipated discharge and actual military exit: J.D., Lee, Dave, and Jon. They received rehabilitation and other resettlement training, their narratives indicated acceptance and preparedness of an impending medical discharge. These narratives, however, were neither homogenous experiences nor did they have similar timelines for their departures. J.D. and Lee described support from their units or military superiors. Dave and Jon stated that they created their own transitional pathway. J.D. had a car accident and wanted to finish his military career in order to retire with his pension, which meant several years of negotiation within the military system. Lee, a unilateral leg amputee, made the decision to exit the military on his own after a short return to duty. Dave, a bilateral leg amputee, returned to the Army and also began studying at university, designing prosthetics. Jon, a triple amputee, planned and managed the building of a new home despite—or in addition to—being a triple amputee.

We will begin with J.D., who had a car accident whilst serving in the United Kingdom. In J.D.'s situation, he stated that he was medically downgraded to 'P-3 (*which*) is *Limited Efficiency*'³⁴ (Ministry of Defence, 2018). J.D. negotiated his future within the military system so he could continue working and complete his twenty years in the Army, which is when he was eligible for his pension. J.D.'s Army physician assisted with this negotiation by keeping J.D.'s physical designation at a lower level (a 'P-3' versus 'P-7'), thus avoiding an early medical discharge. Then,

So, I stayed P-3 until I got to Catterick then I was made P-7, about three years left to do. And um, I'd been told at Headley Court that I could have a medical discharge at any time. (..) So I waited 'til I'd done 20 years and then I went to see a civilian GP. He wasn't sure what to do. But I explained to him what he needed to do. Um, so I went for a medical discharge. It took about 9 months. (..) [T]hat was engineered to give me a 'gardening leave' so that I could get back home and sort everything out for work and things. (..) I did all the resettlement through the job-seeking things, writing CVs and all that. (J.D.)

According to J.D., he '*spread out*' his resettlement in order to take updated training, look for work, and prepare for his military exit.

Another participant, Lee, also went back to duty post-injury. Lee suffered a lower leg amputation after being hit by a car engine on the side of a motorway and returned to his job with the Royal Marines after receiving his rehabilitation. He said the following about his desire of maintaining his military career versus the realisation of his bodily limitations:

I went back to my old unit and I started "Phase return to work". They were very, very supportive. I had a load of jobs that I could do and I stupidly, looking back, I thought that I could still work operationally. So, I'd go back to Chicksands, where I worked, and they would basically... they humoured me. Looking back on it, they, they allowed me to come to the conclusion I could no longer really strictly do it. (Lee)

The fact the Lee was offered the chance of returning to his post demonstrated the Royal Marines' openness to retaining someone who has experienced an injury but also has certain trade skills.

³⁴ From the PULHHEEMS Administrative Pamphlet: 'P3 – Medically fit for duty with *minor* employment limitations' wherein a 'P7 – Medically fit for duty with *major* employment limitations.' Emphasis added.

However, the reality was that without one of his legs, Lee could neither walk well at that time nor be deployable if he was needed outside of the United Kingdom.

It was important to Lee that he was supported by his colleagues but, too, he was allowed the time and space to realise he could not perform his military duties to the level to which he was accustomed. Therefore, Lee turned his attention to improving his walking abilities and rowing with an all-injured ex-service member team, 'Row2Recovery', in preparation for an Atlantic Ocean crossing.³⁵ The Row2Recovery team 'supports Adaptive Rowing for the British Military Wounded, Injured and Sick in partnership with British Rowing and Help for Heroes' (Endeavour Fund, 2016). Sport, in particular adaptive sport for injured service personnel, was introduced for previous war veterans' rehabilitation (Anderson, 2011), with a return to using sport in rehabilitation due to the increased number of survivors from injuries in Iraq and Afghanistan (Brittain & Green, 2012). Chockalingam et al.'s research in the US (2012) asserts, 'with support, injured military personnel can channel the psychological and physical trait that they had before the injury into sport and that, in some cases, elite sport can provide a positive avenue for improving fitness and psychological health', which aids in the transition to civilian life (p. 275).

Lee credits this opportunity with enabling him to move forward with his life: *[H]aving rowed the ocean and being part of that Row to Recovery Team, that changed my life as significantly as losing my leg, but in a totally positive way.*' Since the lives of service personnel are structured around physical fitness and sport, the progression to adaptive sport with a team surrounding him meant he was able to continue a part of his life that existed prior to injury, albeit with an all-male crew comprised of injured service personnel. This type of team work, physicality, and post-military camaraderie can increase the mental well-being of injured veterans or currently serving military

³⁵ From the website: 'In December 2015, four military amputees set out to tackle 3,000 miles across the Atlantic Ocean, rowing in constant two-hour shifts, raising money for their fellow injured service personnel.'

personnel, as is found in the research on surfing camps (Caddick, Smith, & Phoenix, 2015) and the 'Battle Back' sport and training course (Carless & Douglas, 2017).

Two participants, Dave and Jon, found the transition from military to civilian to be relatively easy. They were able to accomplish this by creating their own progressive pathway or framework for the transition from military to civilian. Dave, who stepped on an IED and lost both legs, planned out his transition so that he created an '*Army life outside of the army*' by maintaining a routine, being physically active, and attending university for a master's degree. Dave returned to work whilst he was completing his Headley Court rehabilitation. He was promoted and worked part-time in a Personnel Recovery Unit. Dave previously studied an engineering course at university before his injury so turned his attention back to engineering when looking to plan his future:

I'd become involved with the Centre for Blast Injury Studies at Imperial College London on an advisory basis to work with them. And then the following September um, I went to do my master's there. And actually, from a resettle, a resettlement perspective, I had 6 months of doing my master's whilst employed by the military and then the final 6 months as a veteran. So, I got discharged half-way through my Master's, which, I think, was probably ideal. (Dave)

Dave went on to say that his discharge was 'fluid' and therefore it was not difficult for him to transition from being a Royal Engineer to a (civilian) student:

I had that crossover um, and there was no abrupt finish to being in the military cuz I'd already done six months of being a student, discharged, and still had another six months of being a student so, actually it was fairly fluid. I managed to get all my stuff 'in one sock' before going. (Dave)

This type of 'crossover' alludes to being discharged but still being active in something, which was attending university. Dave's approach was more of a hybrid—by combining exiting the Army and entering university at the same time, he was able to use the time to transition rather seamlessly.

Another participant, Jon (a triple amputee), spoke of doing his 'own thing' during his transition out of the military. When I asked Jon about what his plans for resettlement had been and if he had taken any courses on offer at Headley Court, he said:

It was all there I just decided I was doing my own thing. I ignored the whole um resettlement system, if you like, that was in place and I just did my own thing, which consists of me building a house. So, the idea was that, A, I'd have somewhere to move into when I left but B., just going through that whole project management experience doing a big project like that would just be good preparation for me to help me out in the future. (Jon)

It was very important to Jon that he manage his transition out of the military and into his new home and life. He knew that the organisation and oversight skills he had learned in the Royal Marines would serve him well as he built a new home for himself and his family. Therefore, he opted to disregard the institutional courses on offer to create his own transition pathway.

Shocking transition

Several participants stated that their discharge was sudden or that 'someone' had made the choice for them: that the decision of leaving their career was made by the military discharge board. As Jolly's research indicated, the service member did not choose to leave the military, 'it left him' (1996, p. 65). Research done by Moffatt and Heaven (2017) focussing on the transition into retirement report the 'exercising a high degree of choice and control' to be a 'pro-active and agentic transition' that will increase the person's well-being and quality of life (pp. 881, 885). As previously mentioned, a service member's viability of carrying out their military responsibilities depends on having a medically fit body so when they have gone through all rehabilitation available and are still unable to perform duties, they are eventually medically discharged (Ministry of Defence, 2017). Hale states, 'Military culture comprises strongly structured symbolic systems. Its systems of rules, specific ritual objects and hierarchical social structures confer shared meaning to actions, changes and transitions' (2008, p. 308). When the service member is faced with leaving

this culture of 'shared meaning' and all the people who understand it, they experience a loss of specific resources, such as cultural capital (Cooper, et al., 2017) and a sense of identity (Cooper, et al., 2016; Walker, 2016). Cooper et al. (2017, p. 54) state that cultural capital is 'embodied and valued within the military institution, including subordination to rank and the symbolism of the uniform, that do not translate into the civilian community', thereby affecting the service member's transition.

Several of the ex-service members were unsure of what vocation would replace their military career, causing them anxiety over what to do next (Walker, 2012; Higate, 2001; Higate, 2013). They expressed being in the armed forces was the only thing they had desired since being small children. Others stated that it was the only thing (career/job) they had ever known and could not imagine doing anything else. Much like the 'fear of re-entry' that Frank (1995, p. 107) details in the narratives of hospitalised patients, leaving the military institution meant 'one's real trouble begins' and this is seen in the narratives of these participants. Transitioning out of the military and attempts at finding a replacement career after being injured was quite arduous. Bergman et al. (2014, p. 63) state that 'reverse culture shock' can create struggle for military to civilian transitions, due to a 'prolonged period of absence [from the civilian culture] and adjustment to a new culture [the military], both the individual's frame of references and the environment he or she left have changed', which cause 're-entry problems' and 'difficulties'.

A.D., who served in the military for two decades, narrated 're-entry problems' when speaking about his deployment experiences and transitioning home each time after the deployment. A.D. stated that he would remind himself that his job experiences whilst militarily deployed were not '*normal life*' in the broader scope of things. His words illuminate how distinct his military identity is ingrained due to the types of (everyday) life-or-death occurrences in his career as a fighter pilot and the frustration he feels when civilian problems surface, but also that reintegration is tricky for many reasons:

And you get back from that (deployment and being shot at) to normal, normal life...and it's quite difficult to...it's like living almost in alike you're looking at the world through a different coloured lens to everybody else around you. And you have to force yourself to realise, "No, this is real life. That intensity and the adrenaline rush and the closeness you feel with your buddies in combat is not 'real life'." (A.D.)

This account reflects the difficulties and ‘challenges’ for Afghanistan and Iraq veterans’ transition when returning home after a deployment (Ahern, et al., 2015) as well as the ‘loss of the military structure’ and ‘all-encompassing environment’ that the armed forces experience (Cooper, et al., 2017, p. 54). A.D. further elucidates a multiplicity of reintegration issues that a veteran must deal with when sent home after discharge, which feel like they occur simultaneously (Stein, 2008):

So add to that [frustration with civilians], injury and loss of that identity and geographical loss from those people that you're close with, because you're given to wherever, be at home or um, or wherever you chose to settle and injury and not moving on to a different career and marital breakup and everything and the utter lack and inability of the Veterans Agency, the Royal Veterans UK now, to communicate or make a decision in any meaningful, timeful [sic] ones, is gobsmacking. (A.D.)

This statement encapsulates how veterans can experience an almost overwhelming ‘everything all at once’. It is an example of the abrupt disorder, or ‘reverse culture shock’, (Bergman, Burdett, & Greenberg, 2014) that can exist for medically discharged veterans: adjustment issues, the differences between military and civilian mindsets, loss of relationships and career, and the lack of support from the military agency that is supposed to care for them. The complexities of re-entering civilian society mentioned by A.D. demonstrate feelings of being stunned, alienated from a familiar community, the inability to (re)enter into paid work, and experiencing familial problems, all of which can lead to an unsuccessful transition period.

Further, A.D. stated that only his ‘mates’ will continue being part of his life because the military did not need—or want—his service. Once injured, he no longer served a purpose within the organisation (Koenig, Maguen, Monroy, Mayott, & Seal, 2014). Therefore he does not feel like

he exists in that particular system and experienced a difficult 'reverse culture shock' (Cooper, Caddick, Godier, Cooper, & Fossey, 2016; Mamon, McDonald, Lambert, & Cameron, 2017):

Once we're out the door, we might as well be dead other than a pension. Um, but that's like any employment pension of that variety. The day you leave, you might as well never have existed, outside of your mates. (A.D.)

As mentioned previously, A.D.'s military exit and transition did not include much of a recovery pathway or rehabilitation, as he found himself being sent home to rest and recuperate, without a proper diagnosis at that time, and without his military support system. Whilst others were able to experience more 'stages' in their transition (hospitalisation, rehabilitation at Headley Court, etc.), A.D. did not have these once he returned to the United Kingdom. A.D. experienced Stein's (2008) 'conflated' transition wherein he described his military exit as occurring without proper transitional 'steps'. He found himself with only his former colleagues serving as the connection to both his military career as well as the 'memory' of his injury in Iraq. Schrader (2019, pp. 65-66) states service members 'become the excess' to the 'security dispositif', meaning the military system has used the service members for its purpose and no longer requires them to function as a 'conduit' that (State) power 'passes through'.

'Taken away'

For several participants, the idea of their livelihood having been 'taken away' was undeniably palpable. The termination of their military career was jarring to them, both physically and mentally. As Pav, who was in a vehicle hit by a suicide bomber, stated: *And then, all of a sudden, it's gone, and it wasn't my choice.* Other narrations of incredulity demonstrate that there is still a level of disbelief even though it has been many years since their discharge:

When (...) I realised I wasn't going to be a Marine anymore, I didn't take it very well at all because I was 27, 28 years old. I was in my prime. I was loving the job I was doing. For somebody to take that away from me, when you've worked your whole life for! (Paul)

Paul continued, speaking about what he had given up or missed whilst he was serving his country and doing his job: *'I've missed my kids' birthdays, I've missed Christmases, to be as good at that job as I could be. So, I took it really hard.'* His narrative encapsulates the argument put forth by Cooper et al. (2017, p. 57), that having participated 'in a military career and [having felt] a sense of belonging in that environment, personnel [had to] assimilate and be immersed in the expected culture'. Paul had immersed himself completely and found himself on the 'outside' of the organisation that he felt he had given his all. The military organisation—the greedy institution—asserts Hale (2008, p. 12), 'controls the demands: the individual does not get to choose when and how to comply' and this holds true during service through their discharge. 'The system', argues MacLeish (2013), 'should decide for itself how he is to proceed and what is to become of him' (p. 110). This 'system' is what controls the future of the injured service person by expelling them from the armed forces. When a service member was medically discharged, participants expressed it was difficult to find a new path forward whilst they transitioned out of the military.

Paul expressed that his career was taken from him when he was not expecting it and his career ended due to his war injuries preventing him from continuing to serve. Colin's narrative of being forced to leave the Royal Air Force is another of rejection and disbelief. He, too, felt it was 'taken away':

I was head of my trade! It was all taken away. I don't think knowing it was going to be a medical discharge necessarily softens the blow. I think what it does, is it kind of sets it in concrete that you've lost your job. And I think that is, well, it's just being hit with a hammer, that is. Um, to suddenly find the organisation you've given 26 years of your life to, particularly your healthy years, suddenly doesn't want you anymore. And so that was, that was difficult.
(Colin)

These feelings are similar to people who experience issues with retirement. According to Kim and Moen (2002), this life course transition of retirement 'may lead to diminished well-being, as individuals lose their occupational attachments, their social network of co-workers, and a major

anchor for their identities' (p. P212). Colin's narrative clearly expressed these feelings of a difficult transition.

Other participants indicated that they were in a state of being 'lost' or facing everyday boredom because of their medical discharge from the armed forces. In particular, Mark said that he *'had plans of being a Physical Training Instructor after Afghanistan, potentially going down the Special Forces route later on. But that had all been taken away from me and I was lost.'* J.P. served ten years in the Royal Marines and stated that his days in the military were *'fast-paced, bloody adrenaline every now and again'*. As he continued, his narrative was mournful: *[N]ot that much adrenaline pumping through me in a while to be honest. It's a sad existence.* I followed up, asking if he missed the military, he emphatically responded:

I do! Yeah! I mean, beforehand, you'd be going out on exercise every now and again, jumping out of helicopters, bloody...just yeah! There was always something...like, to keep you excited. Although, a good 70% of being in the Marines was boring. Like, doing absolutely boring crap. There was always "Oh, we're doing this next week" and you're looking forward to that but most of it's boring. But now...there's naught, really, to compare. But (..) Yeah. Can't complain, although I do (..) all the time. (J.P.)

This loss of the familiarity of their previous career, both the excitement and the boredom, as well as the loss of their friends, impacted the participants deeply. It is worth noting how much Paul missed his former military life. He was the only participant who expressed how much he *'loved it'* when speaking about being deployed and the experiences in-theatre:

[S]o you're just focussing on your mates and your job. It's awesome! I love it out there...I loved it... well, that's why I went [deployed] all the time. I loved it! (Paul)

Then I prompted Paul, asking, *'Since you went so many times, was that your choice or...?'* He responded:

'Yeah, yeah...so. In the Marines you're based at unit, say for two years? It's a draft, so every two years you get drafted. So, I sort of cunningly, well, I don't

know if it was cunning, but I was at 40 Commando when Afghanistan first kicked off in 2001. And then I knew they were going to Iraq, so I stayed there. And then 4-2 were going to Afghanistan, so I sort of moved units again then. So, I was chasing it around a bit. You know, cuz I loved it! (Paul)

A.D. also addressed loss, specifically about identity. As he was realizing how his traumatic brain injury was impacting his physical abilities, he was also suffering the loss of his marital home and relationship:

.... [I was] not able to drive, not able to work, lost my home, lost my girls, or I lost waking up with my girls everyday... Uh, and completely loss of identity and who I am and the brain injury itself, and trying to understand what the hell to do about epilepsy. (A.D.)

The participants above were most expressive about the moment they realised the reality of the situation. Their narrations display quite vividly the impact of being judged physically unfit, resulting in their discontinuation of service in the armed forces. Perceived 'bodily betrayals' such as 'shaking, stuttering, [or] incontinence' will 'jeopardize the dependability of [their] bodies' (Howson, 2004, p. 23) and the military, as an organisation, has mandated it must have dependable bodies for executing its remit. A.D. describes the end of his career around the stigma of an involuntary discharge rather than a chosen (and preferred) retirement. He stated, '*I did not want to be medically discharged. I just didn't want to have, what, to me at the time, was like a shadow cast over you of being medical discharged rather than leaving under your own steam.*' The participants' loss of agency in deciding their future was tangible, as was their experience of feeling stigmatised (Goffman, 1968; Scambler, 2006; Hockey & James, 2003) due to their continuously problematised embodied existence.

'Like a bereavement'

Other participants have narrations that include grief and bereavement (Giddens, 2005; Albertson, 2019). These feelings can be compounded by the loss of friends in combat, posttraumatic stress disorder or depressive symptoms (Pivar & Field, 2004; Mobbs & Bonanno,

2018; Finley, 2011). In regards to their future, 'Even though [they were] rebuilding', states Mayhew (2017), they were 'also grieving deeply' (p. 221). As participants live a new life outside of the military, they express their feelings of loss after the departure from their former military community. The following participant, Pav, stated quite clearly that the medical discharge was a significant loss, which needed processing:

[S]o I've accepted that um, I will always feel this way and I look at the loss of what I had, really, um, almost like a bereavement. (Pav)

This 'sense of loss' is supported by Herman and Yarwood's (2015) research with veterans, 'feelings of separation from a lifestyle and career/vocation are strengthened if the individual is not ready to leave, which in turn has implications for their attitudes towards engaging with the transition process' (p. 45).

Betwixt and between transitions

One participant, Andy, was very forthcoming about the chaotic feelings he had during his transition out of the Royal Marines. Andy rationally described the reality of being injured in a career that explicitly depends on the physical ability of its workers and the ensuing consequences if that worker no longer is deemed fit. I have kept his hesitations in this passage to relate the apparent difficulty he had in articulating it to me:

Yeah, also if you're either fit you can back to your unit or there'll be a stage where (..) obviously, the time will come, sadly, for some people, where a medical discharge is, is on the cards. And em, I think that, again, that's, that's what some people can struggle with... knowing that, you know, ... they don't want that day to come... At the end of the day, you have been blown up, you know. You have been, your body's been mutilated; you're missing parts... You're never gonna have a perfect walking gait... You're never gonna walk 100% pain-free. (Andy)

Despite the unambiguousness of phrases such as 'you've been blown up' and 'you're missing parts', Andy's quote is enlightening in that it encapsulates the indefinite space the war-wounded

experience. It is revealing how he uses words such as ‘sadly’ and ‘struggle with’ and ‘they don’t want that day to come’ as a way to juxtapose himself from people whom he thought did not accept the corporeal loss.

Andy had a narrative that was not just one thing (acceptance) or another (grief)—it was a messy mixture of reality and realisation of his injury, or, as Herman and Yarwood (2015) suggest, it was a ‘sense of ‘betweenness’ (p. 47). His narrative was neither wholly about resiliency and triumph nor entirely about transitional troubles. In other words, Andy, along with a few other participants, could be rational and pragmatic about what had happened to his body (and his military dismissal because of it) in one moment, and, within the span of a few minutes, told me something that appeared contradictory. After serving operational tours that wounded them, veterans ‘may face challenges in post-deployment transitions that are interrupted by disability or trauma and require rebuilding their sense of the world, self, and competence’ (Elnitsky, Blevins, Fisher, & Magruder, 2017, p. 114).

I focus here on Andy’s troubled transition narrative—how he presents his acceptance of discharge preparation for post-injury life by working with a Life Coach, and yet reveals the emotional issues when he was standing before the medical discharge board. This ‘crisis of control’ (Frank, 1995, p. 30) is what some of my participants revealed. Participants understood that they could not control their bodily injury and the corporeal changes the injury brought, but they found some ways to predictability in life. In this case, Andy met with a Life Coach. Once Andy completed his meetings with the Life Coach, he had a prepared motivational talk for presentations and workshops. Reflecting upon that groundwork for his post-military future, he said:

I feel like I've had a relatively smooth, kind of, transition compared to a few lads I know. But I think that was em, a lot down to, like we mentioned before, straight away...I wasn't one of these people who was holding on to being in the Marines. I kind of, you know, I made peace with that very early on that. You know, it wasn't meant to be. And I started, then, you know, forming the blocks for the next, kind of, part of my life. (Andy)

But then later in our time together, Andy admits that he had some turbulence with his transition out of the military. He seemingly accepted and denied what it meant to him as he transitioned out of the Royal Marines due to a medical discharge. In other words, he acknowledged his body was in an unacceptable form to be retained in the military and his inevitable, expected discharge was forthcoming, however, his narration implies he rebelled against it. In this state, he was, as Butler suggests, a 'figure in crisis, a figure that enacts a crisis it cannot control' (1993, p. 21). Andy narrated it as something that was accepted and expected...until the moment he was discharged.

When Andy mentioned leaving the military, he began with a rational approach of knowing his injury meant leaving the Royal Marines:

I knew in my head from Day One I probably wouldn't be able to stay in the Marines. You know, move forwards with a medical discharge. It was actually, there's no reason for me to stay in financially, career prospects, what I wanted to do, home life...everything was leading to say 'You're best going down the medical discharge route.' (Andy)

Colin, discharged with a spinal cord issue, also expressed a sense of being 'in between' (Bridges, 2009) during the process of resettlement and discharge. Colin's narrative revealed indignation at being trapped amongst multiple issues: living in military quarters whilst preparing for his medical discharge, having served for an entire career, and losing it all due to the failure of the body:

[T]he last thing I want to see is service men in uniform...um, because it's just like rubbing it in your face, really. You know, particularly having been a Warrant Officer as well, it's not like I went out as a Junior Rank, with little experience. Um, to have gone out...you know, I was head of my trade! It was all taken away. (Colin)

Ken, a bilateral above knee amputee with the loss of many fingers, stated that his experience of transition was that he was '*[I]n that holding pattern at the moment. I'm like in a tunnel. The light's at the end of it. The more I move towards it, the further it moves away.*' This 'holding pattern' leads to a form of stoicism and accepting the situation for what it is.

Stoicism: 'It is what it is'

Pav, a participant who served for twenty-five years in the British Army, described how he sees himself in the world:

[Y]ou join at a period at sixteen, of adolescence, and it forms part of your basis of adulthood. And whereas you haven't got, you know you're not doing college and university and everything. You're in the military. That forms the basis that is going to continue in later life. That's the norm for you, which comes, again, to that deconstruction bit: turning you back into a civilian. (Pav)

The observation made by Pav is the reverse of what Soeters et al. (2003) call the 'process of deconstruction of their civilian status', which they assert, occurs during basic training (p. 250). Pav's concern reflects that the time spent during basic training to be culturally integrated into the military, is then necessary in reverse during resettlement after discharge, achieving the 'deconstruction bit: turning you back into a civilian'.

Military separation can be a continuance of previous military modes of being, presenting a space for a need to navigate the changes in identity and abilities (Mobbs & Bonanno, 2018; Sherman, 2005; Walker, 2012; Bulmer & Eichler, 2017).³⁶ Stoicism is just such an example. For instance, A.D., a former fighter pilot, currently has an assistance dog, ensuring his daily safety and also warning him of oncoming seizures. Due to his various physical issues his days are drastically different than they were whilst he served in the Royal Air Force. A.D. stated:

I'm very stoical...as in 'It is what it is'. And if it happens to be shit, well, then walk forward till you're out of the shit. Or as far out of it as you can be. And if it's staying shit, well then, just suck it up. 'Embrace the suck' as the Americans would say. I love that expression! I think it absolutely typifies...not typifies...It absolutely covers what I think people need to do a bit more of. (A.D.)

This stoicism is indicative of the 'carry on' attitude instilled during basic training that participants reported (Hockey, 2002). For example, Ken opined:

³⁶ See also a short essay by Andy Owen, "Ethics on the battlefield", <https://Aeon.co/essays/>.

It's just what it is...life is...life is what it is. (Ken)

Paul, a former Royal Marine, had five failed limb salvage surgeries. As previously discussed, Paul later opted to have his lower leg amputated. Paul made the decision because it was important to him to be capable of physically interaction with his four children, however, he acknowledges that the damaged leg, in addition to all of his other injuries, had a negative impact that affected his daily life:

Yeah...my life is a fucking car crash. I'm not gonna lie. I look at everything as it is what it is... No point in grumbling about it. It happens for, not a reason, but everything happens, and it happens. So, you try and make light of it. (Paul)

The quotes above exemplify some of the difficulties faced by medically discharged military personnel coming to terms with their physical limitations and how it impacts their identity transitioning into civilian society. As J.P.'s quote earlier in this chapter reflects, exciting and boring coexisted during his military career, but his current days are not offset by much excitement because of the toll that physical exertion causes to his injured leg. Stoicism serves as a mechanism of dealing with Paul's 'car crash' of a life and, whilst that should be grounds for 'grumbling' or complaints, stoicism emerges to accept the situation and shapes the narrative. Their ability to be stoic affects their interpretation of the civilian world, but acceptance of the situation does not mean the participants do not attempt to control other aspects of their post-injury lives.

Issues returning to civilian society

Continuity of a military identity in narratives was demonstrated in two distinct ways: how participants described the way in which civilians deal with problems and the importance of maintaining military friendships. Several veterans did not perceive troubles in the civilian world as being true difficulties. 'Civvy' problems simply did not equate to their exposure to, and experiences

with, death, dismemberment, and disability. For friendships, many told me that it did not matter if their friend had served alongside them (in battle or elsewhere). Those in my research fondly spoke of formed—and continued—bonds with their traditional counterparts in the United Kingdom Armed Forces but also American, Australian, and South African veterans. Chances of meeting fellow ex-service members typically occurred in rehabilitation or at Paralympic-type sports games, such as the Invictus Games. Those exchanges were always in direct contrast to interactions with civilians.

Tolerating a civilian mindset

Entering into the civilian world was difficult and remains so, for many of my participants. There are several issues mentioned to me, one of which was the civilian mindset. Even though, as service members, my participants will have ‘travelled’ between the military and civilian worlds. For example, whilst on leave or living off base in a civilian neighbourhood; however, those were temporary movements due to the return to the military institution (Cooper, et al., 2017).

Andy was a Royal Marine Commando for almost seven years at the time of his discharge. Since his separation, Andy has been quite busy and active. He is a motivational speaker, a runner, a personal trainer, has a podcast, and is the father to three children: one biological child and two stepchildren. Andy also co-authored a book, ***You’ll Never Walk***, describing his experiences surrounding his injury and rehabilitation. When he spoke to me about leaving the Royal Marines, Andy mentioned he had to ‘*adjust again*’ to the things he considered trivial issues, around which civilians complained. He additionally revealed that being unable to spend time with fellow (injured) service members was frustrating due to this civilian mindset:

And then you have to then, adjust again to the civilian world, it's a bit... and it also, em, it all...like, yeah...no one's issues in, in the civilian world life seem, seem as big as they make out once you've been surrounded by friends with no legs and no arms and stuff. (Andy)

Andy further illuminates a feeling of isolation, which compounds his 'frustration' with civilians:

So, it's kind of, like, so your frustrations will build up and because you're not getting that influx of seeing them [fellow injured service personnel] every few weeks, I think those frustrations can build...(Andy)

This idea of isolation is what Herman and Yarwood (2014) define as a 'liminal' boundary, where one 'seeks to reconstruct their identity' (p. 43). Although military identity is seen as temporal in nature and not fixed amongst service leavers (Walker, 2012), several of my participants still felt a continual disjuncture between themselves and 'civvies'. Maringira et al. (2015) claim that 'once the soldier is made, there is no going back to the civilian way of thinking and doing' (p. 32). This is further highlighted by Paul when speaking about his mindset after he left the military:

I've got quite a different perspective on life than what I used to have. Whereas I think every day that I'm lucky to be here. (Paul)

Paul addressed his realisation that civilians spend time on unimportant, frivolous issues, or, as Finley (2011, p. 150) asserts, 'unnecessary worries'. As he mentioned he is 'lucky to be here' and the possibility of death can change one's perspective about problems, or 'menial crap':

And, I haven't got time for bullshit or just the menial crap in life, you know? Cuz...It winds me up. That's why I'm not on Facebook, because people moan about "Oh, I've got tax the car." Well then fucking go and tax your car then! This involves going back, make a change, do something, make a choice. Change something! (Paul)

Paul was explicit in his aggravation with civilians' complaints and lack of action. In other words, he does not tolerate people who verbally complain and then do nothing to resolve the issue. Paul is not alone in this attitude. A.D. also expressed this sentiment:

I get immensely frustrated with...."Really, you're getting wound up by that on Facebook? Really? That's what winds you up? Seriously? Nobody's trying to fucking kill you today, asshole! Maybe calm down about Facebook or whatever trivial crap it is..." (A.D.)

Issues the civilians complain about are perceived as being easily resolved, not necessarily life changing, or worse—as the majority of my participants experienced—life threatening. As A.D. exclaimed, ‘*Nobody’s trying to kill you today, asshole!*’ Narrations of understanding the military-civilian mindsets divide could not have been clearer.

Below, J.P. also spoke of being with civilians who complain, as they do not have ‘*massive problems the way I see problems*’:

I get a bit short-tempered with people when they've.... they've got like petty little arguments, like...I don't even want to get into it.... It just doesn't touch me on....It's part....and I should be receptive to it... I'm just, I'm just not. If I... it's just.... they ain't got massive problems the way I see problems. (..) [W]hich is bad. But that's how am...I'm sorry. (J.P.)

His apology took me by surprise. I always ensured the participants could see I was an empathetic listener by not judging them or what they were saying to me. So, in this particular instance, I followed up on his indication that it was ‘bad’ for him to perceive problems in a different way than civilians:

Allison: Well, would you say that it's 'bad'? Or it's quite circumstantial -- that the experiences you've had, um...are quite different than what others have had?

J.P.: Um, yeah... It's hard to say you've had these problems up here. It's hard to get in touch with people's problems when you don't see 'em as problems? I think that's one of the points of friction that I have with people.

Participants explained civilian issues are viewed as not ‘real’ problems, that they are complaints or choices. As Andy clearly opined, ‘real issues’ are having ‘*no legs and no arms and stuff*’. Frustration levels were palpable when the veterans mentioned the incomprehensibility of civilians’ complaints. This perceived ‘friction’, as J.P. called it, between the military and civilian communities reinforced the sense of military identity and shared experiences within and across participant narratives.

Military friends: 'They get it'

One of the interview schedule items addressed relationships (friends, family, or significant others) and how participants narrated their interactions. Some participants spoke about having a close family or, unfortunately, unsupportive family members but this inquiry was especially helpful in getting more information about military friendships. Many described to me what constitutes a 'real' friend, which typically meant someone from the armed forces. As stated by several participants, close friends did not necessarily serve in the same branch as the participant but there is a code of behaviour, an 'ethos'. This code connected service members and veterans' understandings of each other in ways that might be unfathomable to civilians. Being in the presence of others who truly understand was vital to my participants upon separation from their military community. The military bond's importance was evident for the majority of the participants post-discharge. When asked about friendships, J.P. stated:

I mean, I wouldn't say they are close friends. I would go out with a drink with them. I can't really talk to 'em about stuff. (J.P.)

Pav's words also demonstrate the divide that exists for former service members when dealing with civilians. Continuing to identify with the military community carries on well past discharge dates because there is a lack of common identity and experiences. This 'collective identity' (von Bredow, 2003, p. 88) of mutual understanding and shared background, which 'demarcates members from nonmembers' is evident by Pav's statement:

And it's hard to talk to people who haven't experienced it...really, you feel at ease when you're talking to other people that have because they get it. (Pav)

'Getting it' refers to understanding all the elements that made up his military experiences—upheaval, danger, trusting your colleagues, loss, community, et cetera—that a life-long civilian would not fully comprehend (Binks & Cambridge, 2018; Herman & Yarwood, 2014). Pav continued,

expressing that there is a 'code of conduct' that is not found outside of the military, specifically with friends:

Within the military you have a code of conduct, values, and standards and integrity, loyalty, truthfulness, fitness, you know... your comrades, your fellow service men, all come into play. And when you go out into that civilian life, you sort of you don't realise until you're out, how much you adhered to those values and standards. You used to think you just paid lip service to the poster. But it wasn't. You actually had all of that and took it for granted because it was there in the people you worked with. You don't get that in civilian life and you find yourself, um, just on people's characters and assessing them on those values and standards...and [you're] lucky to find somebody with three or four of those values and standards, yet you're used to the whole package. And it's realising actually, in the military, you're the minority compared to the civilian population. And it's not the other way around. (Pav)

Pav explained that a certain type of person places themselves in dangerous situations as a career, which is what ultimately keeps him from bonding with civilians:

And so it takes a long time to adjust and trust people 'outside the wire', as I would call it, once you're out of that. So, have I made civilian acquaintances? Yes, I have. Have I made civilian friends? No, I haven't. (Pav)

Similarly, J.P.'s response about friendships was, '[T]here's only like one good friend that I've got 'round here and he's a veteran himself, although he was in the Army.' J.P. told me that his friend had been injured and medically discharged as well. When I asked if the shared experience of being injured and separated from the military gave them a common bond, he said:

Yeah. I mean, we were best friends anyway but that connection just...it's like, he's one of the only people I can really talk to about it. Vice versa. He can talk...we talk crap anyway, but I don't really talk about this sort of stuff to, say, my dad or my girlfriend...or....cuz it....you know....it's just....different, innit, I s'pose? (J.P.)

J.P.'s reference to 'this sort of stuff' is indicative of his stoic approach, believing his experiences are too different from anyone else's except another veteran (Sherman, 2005). Therefore, there is no point in complaining about or discussing problems with anyone other than a veteran. Unlike some civilians, a fellow service member does not always probe with what can appear as insensitive

queries, and understands what happened without saying much—if anything at all (de Medeiros & Rubinstein, 2016).

I found this in Colin's narrative of his '*network of friends*' that included other WIS service personnel or veterans that are part of a power boat racing team in which he participates. Colin's network consists of other ex-forces, such as a friend he met when joining the military, '*[W]e joined the Air Force together*' and retained that friendship throughout their military careers. Additionally, Colin was able to discover new friendships through a boat racing programme:

I'm part of a team that does power boat racing. In fact, we came down to Southsea a few years ago. (...) That gives me a network of friends as much as here [charity organisation] does. It's the same group of people. And it's WIS veterans here - wounded, injured, sick veterans, WIS. And it's WIS veterans who are part of the team. (Colin)

These friendships are positive during the military-to-civilian transition as well as life afterward for veterans psycho-socially (Brittain & Green, 2012; Carless & Douglas, 2017; Caddick & Smith, 2018).

Attempts at finding agency after medical discharge

Post-discharge, my participants faced a 'hybridity' of medical and mental care (Herman & Yarwood, 2015; Bulmer & Eichler, 2017) due to seeking care from various sectors, such as the NHS and military charities. For example, Colin spoke of seeking care from the NHS but realised the counsellor was ill-equipped for a veteran's experiences.

When you are serving...my experience of it is, I got looked after quite well, you know, whatever the procedure was. And I suppose I was probably more open about it actually...because I'd be wearing a uniform and so would they [the GP or Medical Officer]. So, there's already a link, you know, a comradeship that you could speak to this person and they would understand. [...] And the problem I had with the NHS, my very first appointment with a psychiatrist, I walked in and he said 'I've no idea what you did in the military. I've no idea how I can treat you or help you.' And, of course, I stood up and walked out because, for somebody with depression, what's the point of having somebody

in front of you saying they can't help you? And yet, he's a 'specialist'. So, I walked out and never went back. (Colin)

After that experience, Colin sought out a military charity because of its ex-military team members and military connections. Colin knew he needed the assistance of someone like him, 'wearing a uniform', so he could feel the necessary connection to a shared (military) past.

There is also the possibility of how a civilian doctor or therapist might make the veteran feel judged: 'Worse than merely misunderstanding, civilians offer diagnosis that judge the soldier' (MacLeish, 2013, p. 122). Due to issues with a civilian-military divide in the area of health care, the opportunities increase for military charities to assist veterans. Thus, the binary between military and civilian assistance become 'blurred' as Herman and Yarwood assert (2015) when applied to veterans' aftercare, as is indicated by the increase of 'third sector' military charities in the United Kingdom. Examples of these charities are the Royal British Legion³⁷, the British Limbless Ex-Service Members Association (BLESMA)³⁸, and the aforementioned Help for Heroes. For instance, the charity known as Help for Heroes began in 2007 by Bryn and Emma Parry in order to 'help those who have put their lives on the line in our Armed Forces' (Help for Heroes, n.d.). The impact of the third sector, specifically Help for Heroes (as mentioned earlier), was integrated into the recovery pathway.

Other issues raised in participant narratives following their military exit involve trying to find agency and control in their lives: deciding which prosthetist will be the most appropriate for the veteran's needs and adjusting the intake—or discontinuing—of pain medication. Agency and control can be asserted by the participants in various ways, or as Antelius (2009) suggests, their

³⁷ 'The Royal British Legion provides lifelong support for the Armed Forces community - serving men and women, veterans, and their families.' From <https://www.britishlegion.org.uk>

³⁸ 'Blesma [sic], The Limbless Veterans, is dedicated to assisting serving and ex-Service men and women who have suffered life-changing limb loss or the use of a limb, an eye or loss of sight in the honourable service of our country.' From: <https://blesma.org>

‘self-determination can be seen as switching control from the professionals to the individuals with disabilities’ and becomes a ‘story of autonomy’ (pp. 361-363). Through participants’ ‘embodied subjectivity’ (Grosz, 1994), they find areas of control and assertion in their post-injury life, which may conflict with their concomitant experiences of military recovery and medical discharge (Messinger, 2010). What follows are the participants’ stories told to me about claiming agency, when possible, in particular aspects of their life in the years since their medical discharge.

Prosthetic problems: Care in the NHS

The two triple amputees in my study—Jon and Mark—told me about their experiences in America for their prosthetics due to issues with prosthetic limbs in the UK. Another, Lee, explained his problems with his nearest National Health Service (NHS) prosthetists. Some of the NHS prosthetics centres demonstrated a lack of exposure to the advanced technological ‘legs’ that my participants used, which led to problems with the NHS being able to provide adequate care to this particular set of amputees—post-military, physically fit, and highly motivated. In fact, due to the increased concern for current military amputees’ prosthetic needs, ‘the Government asked Dr Andrew Murrison MP to lead a review into the prosthetic services currently offered to veterans by the NHS’ (Department of Health and Social Care, 2011). This review led to the creation of ‘national specialist prosthetic and rehabilitation centres for amputee veterans across the country’ (Department of Health and Social Care, 2011), which enabled nine centres—‘Murrison Veteran Centres’—to provide military amputee care or, if the veteran amputee preferred, they may go to their local centre (Parliament Commons Select Committees: Defence, 2014). The creation of the Murrison Veteran Centres demonstrates veterans’ ability ‘to claim unique entitlements and privileges ... expressed in their rights to state benefits’ (Trundle, 2013, p. 197) within the National Health Service. It must be acknowledged, however, that not all veterans are guaranteed access to this funding nor are they guaranteed approval if an application is submitted. Also, the amputee must apply for their particular prosthetic need to an NHS ‘Veterans Prosthetics Panel’, wherein

funding exists for those who have lost limbs 'whilst in military service' or 'if attributable to an injury sustained whilst in service' (NHS England, n.d.). This panel is able to refuse requests and they only meet once a month, which means it can take some time before a decision occurs. The process also puts the onus on the amputee, stating the veteran can 'seek the support of other relevant clinicians in making the case for their application' (NHS England, n.d.). In other words, one must be the correct type of military amputee to qualify for the special prosthetic funding and, if qualified, one still might not receive the funding if the panel denies the request.

Lee stated he was not eligible for the Murrison Centres because he was not hurt 'in service'. Lee was injured on an UK motorway whilst returning to his military duties at a base, but not 'on duty'. As an example of the NHS care he initially received, Lee said experience with his local NHS prosthetic centre in Plymouth went as such:

They (the Centre) asked me to bring my legs along, (all of) the different legs I had. They basically pointed at them (..) None of the legs that I had with me... they could (not) fix or do anything with, cuz they just never, never seen some of them. (Lee)

Lee explained that he was 'quite shocked actually' because he was told by a prosthetist, 'Look, we never seen [sic] that leg. Can't do anything with [those] leg(s).' When that occurred, Lee decided to travel to Bristol because it is a Centre that deals with the type of leg he had been given in military rehabilitation. Lee was among many participants who, dissatisfied with the care provided, opted for going to where they knew their physical prosthetic needs would be met. This act ensured Lee and others began to be the 'agent of [their] own subjectivity' (Vassallo, 2008, p. 192).

Another example of participants' agency is found in Jon (a triple amputee). Jon discussed the expense of receiving specialist care and how he needed the support of the Royal Marines Charity whenever his prosthetics need updating or replacing. Whilst Jon's prosthetics are technically covered by the finances in the NHS Murrison Centre scheme, he travels to America for care at Ottobock, located in Oklahoma, USA, once he has his new NHS 'legs'. He discussed keeping

'the system happy' because the NHS must 'go through the process of making me a new set of sockets', which are the part of the prosthetic limb that go over the residual leg. This process would also include new 'knees', which are the micro processing knees (or MPKs) that are programmed to 'know' when the wearer is walking, standing, sitting, or other daily things. Jon told me that he was not 'gonna wear the sockets they make me. I'm just gonna bolt the new knees straight onto these ones' and have the NHS prosthetist 'copy the settings from these knees, which were put in by America and when I get back out to America next, I'll just get them to double check everything.' This negotiation within the existing system (the NHS) and going to America with finances provided by the third sector empowered Jon so he could have the prosthetic 'legs' that he decided would work best for him and his daily life.

Mark, too, also chooses to go to Ottobock in America for his prosthetic fittings; this is because of his experiences with them during his recovery, explaining that the consultants *'live, eat, and breathe it (their work). Some of their employees are veterans, limbless veterans, who work for the company'*. Mark discussed an experience that happened the first time he went to America for prosthetic work, where he witnessed the Ottobock prosthetists' dedication to their patient:

We were out about 11 o'clock at night cuz my plane landed and he got a phone call from an old lady who couldn't get this valve out of her leg to take her leg off. He went out to her house at nearly midnight and helped her! You wouldn't get that here. (Mark)

Mark further opined that, in his experience, the NHS system does not have that same 'round-the-clock' committed approach, as it *'is very 9 to 5. And if, if you have an issue out of hours, tough! You have to wait'* versus his experience in America, where they are *'proactive, passionate, and there's a very specialist team of people who go above and beyond what they should do.'* Mark's involvement with Ottobock led to new limb designs *'created based on their feedback and testing and trialling. So, that's the difference. They work hand in hand with the manufacturers. They develop their own [prosthetic learning] "boot camps"'*. Mark concluded by stating, *'that's the*

massive difference in it if you wanna live life as normal as possible! Mark's ability to assist in the design of better functioning prosthetics meant that his daily physical experiences and life would be better. Further, it meant that his involvement helped other amputees, as their lives could be improved due to the incorporation of prosthetic wearers' feedback (like Mark's) to the designers.

Gaining control: quitting pain medications

At the beginning of my participants' hospitalisation and care, pain medication was vital. In the battlefield or upon first being treated by NHS medical services, they received morphine due to their extensive, sometimes life-threatening, injuries. Other participants received pain medicine for their injuries and the resulting chronic pain. The teams at the hospitals aimed to give pain prevention for all of the varying injuries: 'post-operative pain, post-amputation pain, inflammation pain, all the other kinds of pain, as separate things, affecting separate patients' (Mayhew, 2017, p. 159). Whilst removing pain by taking medication was helpful initially, many participants did not like the side effects. The way in which my participants narrate the problems they faced using pain medication indicated that the treatment created physical and mental issues they found unacceptable.

After being released from hospital, the participants stated that they took ownership of deciding when or if they took medication, as well as what was an acceptable quantity. This approach assisted them with asserting 'partial control over [their] past and present' (Messinger, 2010, p. 295). Whilst Mark and Dave mentioned weight gain being a secondary issue, more participants focussed on the reality of addiction and their contempt of that possibility. Participants were accustomed to governing their physical body by following a military regimen; it is conceivable they desired a 'continuity in [their] corporeal self' (Allen Collinson & Hockey, 2007, p. 390) after their military discharge.

Mark came to the conclusion to stop medication whilst at home. After realising he had been *'sitting and staring at the same spot for three hours'*, Mark stated:

'I was given a cocktail of medication, which I hated. I needed to stop the medication cuz (..) I was doing like, sixteen for breakfast, lunch, dinner. I couldn't string a sentence together. I couldn't hold a conversation. My brain would just fry really quickly.' (Mark)

Mark decided his approach to all the pain medication was immediately discontinuing it:

I literally went cold turkey one day. (..) 'If I'm in pain tomorrow, I'll deal with it. And then I'll figure something out.' And then the next day came, I didn't have any pain. The day after came, I was fine, day after, week later....and I was like 'What've I been taking all of this for?' I didn't even need it!' (Mark)

J.P. also chose to stop prescribed pain medication due to his realisation that he *'maybe had a little addiction to it'*. He explained:

I've stopped taking the pain medication, cuz I think I had a problem with the morphine for a while. It's like after...once the initial healing, has stopped and then it was as good as it was gonna get, I was still on the morphine. Like, they still gave, they just kept giving me it, so I was like, 'Alright, I'll have it.' So, I just decided to stop taking it, cuz I weren't in that much pain. (J.P.)

J.P. knew his injured leg was *'as good as was gonna get'* but reveals that the medical team continued prescribing pain relief even though J.P. did not think he needed it since he was not *'in that much pain'*. But once he did stop it, he immediately began experiencing withdrawal symptoms.

He described it as such:

I couldn't sleep for 3 days. I was sweating, so I had to, like, wean myself off it... Pffft. That was, that was an odd time. I've, I've never been addicted to anything like that - I don't smoke and all that, but ...that was, that was a hard time. Trying to wean yourself off morphine. So, I tend to just stick to like paracetamol or ibuprofen (and) keep (my foot) elevated, really, for pain relief. (J.P.)

It is, as Siebers (2008) claims, the 'great challenge' each day 'to manage the body's pain, to get out of bed in the morning, to overcome the well of pain that rises in the evening, to meet the hundred daily obstacles that are not merely inconveniences but occasions for physical suffering' (p. 62).

As Paul indicates below, the number of pills plus the feeling of '*walking around like a fucking zombie*' and being '*drugged up*' was not how he wanted to live his life:

I found out the best ways for me - you know, they give me options of like, they offered me drugs for phantom pain so I started on quite a bit. But I was like, no...the first time I was in recovery with my head injury and stuff like that, I was on like 25 tablets a day. I was walking around like a fucking zombie. I was so drugged up...so I try to stay away from drugs as much as I can. I mean, when I had my leg off, I only took paracetamol for it anyway. I just didn't want to get involved in that drugs things again. Cuz, most of them are opium-based anyway, I was basically a freaking raging heroin addict so..I didn't want to go anywhere near the drugs, so I haven't. (Paul)

Here, Paul is referencing his past when he said, '*I just didn't want to get involved in that drugs thing again.*' He is specifically speaking about his teen years, wherein his path crossed with drug dealers. At that time in his young life, he knew that interaction was not going to end well, which is why he decided to join the Armed Forces. Paul knew he could get some excitement and physicality from joining the military. Terms like 'zombie' and 'raging heroin addict' made it evident participants, like Paul, acknowledged and othered their lack of control over their body, mind, and behaviour due to the medication; nonetheless, they mastered it.

Below, Dave focusses on the pain medication side effect of gaining weight, which was an issue for him. More importantly, though, he acknowledges the mental side effect of '*slowing down his thought process*' as the prompt to quitting his prescribed medication:

In the early periods, the, um, the nerve pain medication is a, was a real problem for weight gain. I didn't like those from ...the perspective that they made...they slowed down my thought process as well. Uh, so I got rid of those medications. I got rid of all my medications within 5 months of coming out of hospital. Um, but they were awful. (Dave)

Participants also spoke about learning that pain was now *'a part of your life'*. As Lee stated below, the reality is that pain exists in their body every day. He even told me it was 'normal' to have it, so much so that one should not focus on it:

It is pain. Being an amputee, pain is part of your life. Accept it, that (it's) normal and then just get on with it. There's nothing else you can really do. (Lee)

Lee's saying *'There's nothing else you can really do'* indicates that the choice is one of the extremes: pain medication with loss of control or no pain medication and being control of one's daily living.

Accepting that there will be pain everyday appeared to be an ongoing task but that is better than being an 'addict' or 'zombie'. It was, in Bury's words, 'the uneasy balance which is struck between seeing the condition as an outside force yet feeling its invasion of all aspects of life' (1982, p. 173). Pain medications had 'invaded' participants' lives in a negative way. Participants realised that gaining control of the situation meant accepting the possibility of higher levels of pain every day in exchange for mental clarity. In this way, pain would be the new 'invader' but one that created an 'uneasy balance' that participants found more acceptable. When I asked Jon if he experienced pain often, he stated:

Yeah, initially you do. You're in a lot of pain. (..) One of the biggest learning points was they keep you on a massive cocktail of drugs for a long, long time. When you come off of those drugs, most of them are painkillers (..) you're in a lot less pain (..) the learning point was that every drug has its intended effect and it has a side effect. And what I was finding, actually, was a lot of them, the side effects were causing more pain than the intended effect of taking pain away. The sooner you get off them and start feeling healthier... the better. (Jon)

Other participants agreed with the idea of being free of medications as a positive change for 'the better'. Pav did, as is evidenced from his narration about ending his daily dosage of pain medications:

Although you're on prescription medication, I would class it as being very close to being a drug addict. (..) It, it, it was a bit of a drug-induced haze, really. Um,

and the only answer, really, you got from the doctors, was to continue on taking them. So, I actually made the choice, myself, to reduce medication to the minimal level that allows me to, to get by. And I'm in a lot better place because of that. (Pav)

The participants who discontinued their pain medications viewed it as something that kept them from being autonomous and independent in their daily life. Addiction to medicine was 'something external that compromises the agentic, desiring self' (Gilleard & Higgs, 2018, p. 7), which needed to end or be avoided so the participants could function in their daily lives without the limitations that a '*drug-induced haze*' would cause for them.

Conclusion

This chapter has focused upon the preparation for and experiencing of medical discharge from the UK Armed Forces. This event took place for all participants and some of them told very vivid stories and recollections about the experience. Narratives of transitions were then described. The themes raised in the chapter were about three types of transitions: planned transitions, shocking transitions, and the 'betwixt and between' transitions. Several participants discovered issues when reintegrating back into civilian society, such as missing their military friends and a lack of understanding civilian problems. Participants' narratives addressed their attempts at finding agency during this stressful time in their lives. Specifically, they focussed on issues surrounding the military exit: prosthetics care and pain medications. They addressed the problematic care within the NHS they received for their prosthetics. Participants described how they approached changing the care to be more helpful to their needs. Others spoke of finding control over pain medications in order to avoid becoming addicted but also ensuring they could participate in daily life rather than being an 'addict', 'zombie', or living in a '*drug-induced haze*'.

Chapter 7: Narratives of Embodied Identity and Physical Autonomy

Introduction

The previous chapter demonstrated how complicated my participants' lives can be following a medical discharge. Participants narrated multiple types of transitions ex-service members experience, and their narratives reflect that the process can be relatively simple or rather complex. Thus far in this thesis, participants' experiential stories attempt to create order out of personal bodily chaos. With their bodies injured and altered, participants tell the stories of rehabilitation, recovery, medical discharge, and military exit. This chapter will turn to the lived effects of trauma and how participants narrate their embodied identity and to offer analytical insights into their experiences of daily life. As Hollander and Gill state, wounds and injuries 'represent the embodiment of a violent past and its ongoing legacies inscribed into flesh' (2014, p. 220), and it is this 'legacy' of injury, impairment, and dis/ability I investigate here. It is with this understanding that I introduce new typologies for physical independence: 'anchored', 'adapting', and 'ascending'. These novel typologies illuminate the variations of bodily abilities that participants narrated. Further, I present the two new concepts of 'conditional corporeality' and 'body rationing'.

Participant narratives demonstrate the complexity of how their bodies have been physically altered—what society may deem 'disabled'—but the participants do not categorise themselves in this way all the time. The tension between abled and disabled causes a strain in the cohesiveness of narratives because most participants speak of themselves as disabled *sometimes*. Not all participants think of themselves in the normative terms of 'having a disability' or 'being

disabled’. In fact, the majority of participants tended to address normality and focus on what they can physically do. The dominant theme within this chapter is about physical autonomy, or independence. However, this salient narrative is one of temporariness because independence and normality are tenuous, non-permanent ways of being for a traumatically injured body; indeed, no person’s body is unendingly static or stable. The other sub-themes within participant narratives are about ‘othering’ and the reality of needing to limit bodily usage each day. Participant stories expose a lived, embodied space between ‘abled’ and autonomous, and ‘disabled’ and conditional, where they achieve a new manner of ‘normality’ and self-reliance in their lives. I use the terms ‘disability’ or ‘disabled’, not due to their prevalence in the medical community or society, but because and where they are found in my participants’ narratives.

Social construction and implications of disability

Whilst it is outside the scope of this thesis to present a complete historical anthology of disability, important concepts that can negatively impact my participants are introduced, such as stigma and dependency. The study of disability has ‘been in the making for years,’ states Davis (2006) and is a ‘political, discursive entity’ (p. xvi). Using the theoretical background of disability studies and its critique of hegemonic normalcy, the aim of this chapter is to employ narrative evidence of a continued embodied resilience amongst the participants and present the types of physical independence.

Negative perceptions, categories of difference, and stigmatisation surrounding having a disability assisted me in analysing what participants said about how they perceive themselves and their bodies. As Achter (2010, p. 49) claims:

Those with visually identifiable injuries such as amputations, burns, or paralysis stand out as ‘wrong’ in a culture that sees bodies through very rigid binaries. A ‘wrong’ body, then, is one that lies outside cultural assumptions about ‘physical health and beauty, ownership of the self, and physical appropriateness,’ and its

appearance threatens the connection between civilians and injured service members.

Criticisms of a medically based definition of disability have arisen in disability studies such that disability is defined to be 'not a physical or mental defect but a cultural and minority identity' (Siebers, 2008, p. 4). Oliver argues disability is 'culturally produced and socially constructed' (1990, p. 22). Further, society is disabling by the existence of inaccessible physical structures and other forms of oppression, like attitudes and laws (Oliver, 1996; Shakespeare, 2006; Santuzzi & Waltz, 2016; Smith & Sparkes, 2008). For example, one participant, Dave, affirmed the difficulty of negotiating physical spaces whilst using his wheelchair versus it being 'easier' when he walks with his prosthetic legs:

'[G]etting in and out of cars, up and down steps, in and out of buildings, through narrow spaces, manoeuvring in general, on and off a train; everything's easier with prosthetics once you're at the stage where you can handle them all day.' (Dave)

Oliver highlights a distinction between disability (or 'disablement'), which is a 'consequence of social oppression', and impairment, wherein an impairment is a 'description of the physical body' (1996, p. 35). Similarly, Hollander and Gill 'recognize that "disability" or "impairment" per se are as much culturally constructed as medically validated' and use the term 'marked' when referring to bodies with physical differences (2014, p. 219). Working with northern Ugandan civilians who were tortured, mutilated, or otherwise harmed by warfare, Hollander and Gill discuss the stigma, discrimination, and societal loss that persons with 'marked bodies' experience daily. These experiences include having difficulties bathing, with sexual intercourse, or being unable to financially support their families through farming, thus creating a person who is dependent upon others for the rest of their life (Hollander & Gill, 2014). Garland-Thomson refers to this as 'differentiating and marking bodies' in an 'ability/disability system' (2002, p. 5). Centuries

ago, this differentiating occurred by literally marking societal outcasts, specifically slaves, in Greece, as Scambler (2009, p. 443) explains:

Slaves were valuable property and to prevent their escape and ensure the return of runaways the Greeks 'tattooed' them: the sharp pointed instrument used for the purpose make a mark called a 'stigma' (the Greek for 'to prick' is *stig*). Today, the usage of the word 'stigma' connotes a mark of disapproval, as likely to be invisible as visible, which allows 'insiders' to identify and disassociate from 'outsiders'. It is the disgrace itself which is marked.

The disabling injuries that the participants have are a 'physical wound', which 'mark[s] their suffering' (Finley, 2011, p. 151). Negative perceptions or judgements of people with disabilities can occur due to stigmatisation, which is 'a social process, experienced or anticipated, characterized by exclusion, rejection, blame or devaluation that results from experience, perception or reasonable anticipation of an adverse social judgement about a person or group' (Scambler, 2009, p. 441). Goffman (1963) argues that stigma is 'an attribute that makes [one] different from others in the category of persons available for [one] to be, and of a less desirable kind—in the extreme, a person who is quite thoroughly bad, or dangerous, or weak. [One] is thus reduced in our minds from a whole and usual person to a tainted, discounted one' (p. 3).

Additionally, uncontrollable corporeal problems can cause feelings of anxiety and the possibility of being stigmatised. The loss of control of bodily functions, such as incontinence, are 'bodily betrayals' and reinforce the concept of stigma, both internally (the self) and externally (society) (Goffman, 1963; Seymour, 1998; Howson, 2004). Adverse societal behaviour concerning corporeal anomalies is not uncommon and has historical precedent, based in eugenics, or 'social Darwinism' (Carey, 2013; Waldschmidt, 2005; Dixon, 2014). Davis (2006) argues that 'Darwin's ideas serve to place disabled people along the wayside as evolutionary defectives to be surpassed by natural selection. So, eugenics became obsessed with the elimination of "defectives", a category which included the "feeble-minded" the deaf, the blind, the physically defective, and so on' (p. 7). For example, Galusca critiques US medical examiners on Ellis Island for rejecting

physically imperfect immigrants in the early twentieth century (2009). Immigrants with 'physical or cognitive impairments' were refused entry due to their anticipated lack of physical independence and capitalistic contributions to society, as they were 'liable to become a public charge' and be dependent upon assistance from society (Galusca, 2009, p. 151). The exclusionary practices, 'in a capitalistic society, designate[s] which attributes are seen as productive and acceptable and which are abnormal or deviant' (Bury, 2004, p. 271).

This 'dependency rhetoric', Galusca argues, is in direct opposition to living in a communal, shared society, as it 'misunderstands the inherently dependent nature of all social relations' (2009, p. 151). Social relations are built upon interactions with each other and no one is wholly independent. The Ellis Island example demonstrates that dependency on the nation-state is to be discouraged and avoided. 'Economic dependency', Kinder asserts, became a 'marker of one's failure to meet the full demands of capitalist citizenship' (2015, p. 33). Dependency has a marginalising consequence and possible stigma for those who are deemed neither autonomous nor societal contributors through their productivity (Carey, 2003; Davis, 2006; Galusca, 2009; Aciksoz, 2012, Kinder, 2015). People with disabilities of any kind can be deemed non-contributors and therefore face social stigma and bias in their daily lives. In the case of post-World War II America, veteran workers and their productivity were correlated 'with the qualities of a certain brand of normative masculinity: independence, reliability, efficiency, and resiliency' (Serlin, 2006, p. 49). Society creates what McRuer (2006) theorises as a 'compulsory able-bodiedness' wherein it 'functions by covering over, with the appearance of choice, a system in which there is actually no choice' (p. 303).

Bias and stigmatisation can impact injured ex-forces as they search for a post-military occupation in the civilian domain in order to continue being 'contributors' through employment (Anderson, 2011). Contributing to society for injured veterans implies one is employed, independent, masculine, and not drawing upon welfare programmes (Hartley, 2013; Aciksoz,

2012). Caddick, McGill, Greaves, and Kiernan (2018) found in their research with older limbless veterans that a 'minimization narrative' of limb-loss placed 'an emphasis on making an equal contribution to that of their able-bodied peers' through employment (p. 28). Whilst all participants in this study draw a medical pension, they all spoke of the desire to work. Many traumatically injured veterans cannot work full-time, or perform specific tasks, due to bodily limitations. Stone and Stone's (2015, p. 68) investigation on veteran employment issues found, '[T]he stereotypes and biases associated with people with disabilities are often attributed to veterans, and serve as major obstacles to their employment'. These barriers to independence exist due to physical issues and because of employers' inflexibility, as one participant stated:

I tried employment elsewhere. Got taken on as an operator's manager for a small company but they let me go 4 days before I'd done a year. They didn't say it was because of my injuries or the fact that medication... I'd done a reasonable job, but I'd had some time off because of my back and not being able to function some days with it. So, they maybe come into play. (Pav)

Not being able to work full-time, or on a predictable timetable, causes issues for physically wounded veterans. (In the following chapter, participants tell stories of addressing the subject of employment.) Participants want to continue being socially productive and struggle with the 'social repositioning' (Zittoun, 2007, p. 206), or transition, due to new 'factual and social knowledge and identity changes' that are based upon their current physical state.

Typologies

In this section, I offer my typologies for future ageing, critical disability, and critical military studies. Whilst I originally began the research working with Frank's (1995) conceptual framework of 'restitution', 'chaos', and 'quest' narratives, I found that my participants' narratives did not fit neatly into these three categories but moved across, between, and sometimes outside of Frank's categorical boundaries. Simply put, Frank (1995) claims that a 'restitution' narrative is the

‘culturally preferred narrative’ of returning to health and normality (p. 83); ‘chaos’ is ‘the opposite of restitution: its plot imagines life never getting better’ (p. 97); and ‘quest’ narratives, which are ‘stories that meet suffering head on; they accept illness and seek to use it [...] that something is to be gained through the experience’ (p. 115).

My participants’ narratives revealed a richness of experiences and also a deep complexity. For example, a participant could be ‘quest’-oriented when discussing their body but ‘restitution’-oriented in their choice of employment by returning to a similar line of work. This is most embodied in Mark (a former Royal Marine), who enters every Invictus Games and who works for an organisation connected to the Royal Marines. Or, they could be ‘restitution’-oriented in their body but ‘quest’-oriented in employment. Over the course of this research, it thus appeared that it might be beneficial to build upon Frank’s theoretical framework. My participants said that things had fundamentally changed—that they are different now psychologically, that their bodies are different physically, and interactions with people are different socially and emotionally. Therefore, in creating new typologies, I focussed on how they described themselves, these changes in their daily lives and routines, as well as how they explained physical independence.

The typologies I offer concern themselves with the narration of embodiment, autonomy, and the ambiguity found within post-injury levels of dis/ability. People who are considered ‘normal, able-bodied’ can take agency and physical independence for granted. Renegotiating corporeal autonomy following an injury can be fundamentally difficult, if it is possible at all. Based upon my research, I propose three types of narratives of physical independence: ‘Anchored’, ‘Adapted’, and ‘Ascending’.

Anchored

The category entitled ‘Anchored’ incorporates the narratives of least physical independence. The term ‘anchored’ is defined as ‘to lower an anchor into the water in order to stop a boat from moving away’ or ‘to make something or someone stay in one position by fastening

him, her or it firmly'.³⁹ I sought a term that was simple, could encapsulate the idea of a lack of freedom of movement, and could also be visualised by the reader. Further, being anchored does not mean one can never move about, but a physical impairment is preventing the participant from being fully free to move about all the time—keeping them from their previously embodied state of complete physical autonomy. J.P. explained the moment he understood how the injury would impact him:

I'd never been injured in my life before. I was like "Yeah, I'll bounce back from this! It's fine! I'll be, I'll be back at work in a couple of months!" but uh....it weren't until I actually saw the state of my foot where they took most of it off and thought "Uhhh, right. This is... I'm not gonna bounce back from this.... as I thought I was gonna." (J.P.)

To return to the anchor metaphor, an anchor, too, takes work to lift up so that the boat can 'go'. I believe this also reflects the reality of participants' daily difficulties in movement plus the need to use an assistive device, difficulties that they expressed through frustrations and refusal to define themselves as physically disabled. Therefore, I have chosen 'anchored' as it suits those participants who are most stoic and limited by their body. Participants indicated—quite strongly—how wheelchairs represented both a physical limitation as well as a negative perception within societal interactions. I introduce a concept below, 'body rationing', that aids in highlighting and explaining the corporeal boundaries participants face each day by not '*smashing into it*' or if they '*do a lot today*' then they cannot '*do much tomorrow*'.

Adapted

The term 'adapted' places participants within the 'middle ground' of being physically independent the majority of the time albeit with issues of pain surfacing each day. Adapted is 'to become familiar with a new situation' or 'to adjust to different conditions or uses, or to change to

³⁹ Definition from <https://dictionary.cambridge.org/us/dictionary/english/anchor>.

meet different situations'.⁴⁰ Both of the meanings of adapted are well-suited for the participants that are in a constant state of adjusting to the physically altered, ever-changing bodily conditions. Therefore, they narrate having adapted to this new way of being—knowing that they are somewhat limited due to impairment and pain levels yet learning to live with the new corporeal parameters. In particular, this concept highlights prosthetic users' need for maintenance as they must '*plan the days the night before*', as Mark mentions below.

As mentioned in previous chapters, participants claim prosthetics enable them especially when following an engrained routine. Mark states that using prosthetics is 'normal' for him and despite his injury of being a triple amputee, he '*had to maintain that [Royal Marines] standard no matter what*'. Adapting the physical standards learned in basic training and military career meant using '*the discipline and regime*' necessary to look '*after the wounds on your legs*', according to Jon. Additionally, Lee stated '*routine gets you through stuff*'—including bodily injury, an amputation, and loss of military career. Dave mentions that '*post rehabilitation*' the '*discipline and the training*' that was '*instilled throughout the previous military career is still there and allows you to get up and go*'. It is during this time of adaptation that participants learn to balance their past physical abilities with the new, altered ones. Andy stated in the last chapter that he '*started forming the blocks for the next part of [his] life*' after his amputation, which meant he could adapt to life on a prosthetic leg in lieu of using a wheelchair or a stick. Dave expressed:

[T]he body is an incredibly adaptive piece of equipment that, um, will be okay in most situations. I've got a massive respect for what the body can do because it shouldn't be able to do this stuff. But it does. And it copes perfectly well with not having two legs. (Dave)

These narratives of adaptation can include the other two: 'anchored', mentioned above, and 'ascending', which is described below. For example, Jon narrated bodily problems surrounding unusual bone growth (heterotopic ossification), which put him in hospital, but he also continues to

⁴⁰ Definition from <https://dictionary.cambridge.org/us/dictionary/english/adapt>.

push himself to excel in physical functioning, as he has raced a canoe for charity. Therefore, participants in the 'adapted' category can experience short-term physical setbacks that place them in the 'anchored' category temporarily (e.g., being in hospital) but know that they will return to daily function upon healing. Also, participants can push their body for a particular short-term goal, such as Jon's canoe race, wherein they are in the 'ascending' category but return to a more regular daily routine afterward because constant 'ascending' is not physically sustainable. The concept of 'conditional corporeality' is introduced below to demonstrate how physical independence is not a stable, fixed condition.

Ascending

Lastly, 'ascending' is for the participants who are most like Frank's (1995) 'quest' category wherein they narrate extremely high physical independence to the point of continuing to push their bodies to the limits (for example, in Invictus Games). Ascend means 'to go or move up' or 'to rise from a lower level or degree'.⁴¹ I believe the term reflects ability of some participants to continue, or exceed, their corporeal status through an ability to achieve (extreme) physical goals. In particular, competitive sport plays a large part of participant narratives. The 'ascending' category highlights participants' narratives about competing in liminal spaces, such as the Invictus Games or the Paralympics. The category reflects the corporeal aspiration to perform at a maximum physical level. Dave is the most evident example of this category. After Dave's injury, he participated in the 2014 Invictus Games and then:

I put myself on a full-time training programme. Um, prior to getting funding and I just kept getting better and better. Um, and then I was put on UK Sport funding after the Rio Paralympics. (Dave)

⁴¹ Definition from <https://www.merriam-webster.com/dictionary/ascend>.

Mark also participates in the Invictus Games, saying '*I stayed away from this stuff initially because they weren't many triple amputees.*' However, Mark changed his mind over time and stated that he was planning on being in different competitive events at the Games:

[What] I'm gonna do is rowing, swimming, hand-biking, maybe running.
(Mark)

Lee referenced his plan to row across the Atlantic independently:

I never, never dreamed of being a world record holder in an endurance event before I lost me [sic] leg. I now am. And I never would have dreamt that I would... It would be a possibility that I would be able to row across the Atlantic. (Lee)

Further, the reported levels of pain are very low or nonexistent for participants in this category.

Mark explained how he 'retrained his brain' by walking on his residual limbs:

I can walk around on the end of my legs with no pain...but it desensitised nerve endings. And I think what else it did, was it retrained my brain because the phantom limb pain and the sensation comes from having, having a limb...and your brain not being able to comprehend the fact that you haven't got it anymore. So it sends the signals to where your toes were because your brain still thinks you've got 'em. So by having that pain, initially, going through here, and then decrease over time, it retrains your brain (..) to say, "actually, this is where your leg ends." Um, I got rid of it [pain] and I never had it since. (Mark)

Dave addressed his how pain effects his days by explaining that he has:

Minor levels of phantom pain. Mostly in the evening, um, when I take the prosthetics off. It's not every day. (..) I used to think it was do with "I trained particularly hard on my legs today" but I train particularly hard on my legs most of the days and uh, I haven't been able to spot the pattern yet. I admittedly have not been writing it down. But yes, I have phantom limb pain on occasion. (Dave)

Another participant, Lee, had this to say about levels of pain—phantom or otherwise—in his daily life:

[I]t's rare that I have a bad night's sleep due to phantom pain. Then you have the actual pain, which is, and there is no rhyme or reason to this. It doesn't

matter if I've been working hard, been in the gym training, if I've been driving, (..) it is totally random. I can't see any pattern to it and it would be once or twice a week. Maybe more. Maybe three times a week. I'll just get a shot of pain. (Lee)

Within the following table, I include summative descriptions for each category. Whilst these are not necessarily generalisable beyond my participants, I found them helpful in evaluating the bodily expectations, limitations, and endurance in daily functioning following a traumatic injury whilst in military service. Further, the types below exist in a continuum for the participants. In other words, a participant can be in one category for weeks, then a health event (e.g., skin lesion, infection, surgery) might temporarily place them in a different category. This type of repositioning or 'slippage' within the typologies is evidenced by Jon's narration (mentioned above, and in chapter five) about going to hospital if he does not properly take care of his body. *(Typologies on following page.)*

Table of Proposed Narrative Typologies

	<i>Anchored</i> <i>Independence</i>	<i>Adapted</i> <i>Independence</i>	<i>Ascending</i> <i>Independence</i>
Daily level of Mobility	Limited physicality and functioning	Can function almost all day, despite pain	High physical function every day
Pain levels	Everyday; Pain is sometimes incapacitating	Often; Pain can 'ebb and flow' throughout the day	Rarely; Pain is minimal
'Body rationing'	Relatively independent every day with assistive device, but must constantly 'ration' body use each day	Amputees report being able to 'put on legs and go'; can be mobile everyday	Athleticism and sport involvement are constant goals; High levels of physical action and exercise each day; (Examples: Paralympians or Invictus Games participants)
Negative ramifications because of body rationing	Yes; causes psycho-social issues due to inability to exert self	Sometimes; If active for days on end, or 'push themselves too hard', participant enters 'Anchored' category until healed/rested	No; Limited to no bodily ramifications in relation to high levels of physical activity

Table 7.1: Proposed Narrative Typologies of Participant Independence: 'Anchored, Adapted, and Ascending'

Furthermore, it is highly possible over time that participants currently in the 'ascending' category will move into 'adapted', and then 'anchored' because of (natural) ageing issues combined with decades of using their bodies in ways not naturally designed. For instance, a below-knee amputee placing their body weight on their knees (where previously their feet and other muscles had supported their weight) creates physical stressors to which a body does not naturally acclimate.

Caddick et al. (2018) indicate ‘a high prevalence of pain and comorbidities (e.g., arthritis, back pain, residual limb pain) was undermining veterans’ quality of life several decades post-amputation’ because amputation ‘is not a static disability’ (p. 25). Additionally, Wilson (2013) argues that people who experienced polio but had ‘passed’ during their youth found that the resurgence of the disease in middle age ‘brought an end to the deception’ and ‘had to renegotiate their relationship with their disability’ (p. 14). I mention both Caddick et al.’s and Wilson’s research as acknowledgement that, whilst a precise future is unknown for each participant, it is a fact that every body faces decline as it ages and, the crucial point is that participants’ bodies have gone—and continue to go—through unique physical circumstances since they sustained their injuries. The fact that most participants in this research are young and physically active adds weight to the issues surrounding ageing with injured bodies.

Narrative representations of embodied dis/ability

Rejection of ‘disabled’ label

‘It is not the ‘inherent’ nature of disability that matters, but the labelling process, which categorises people by their position in relation to the dominant structures and values of the society’ (Bury, 2004). The rejection of being labelled ‘disabled’ is not uncommon for former military personnel. For instance, war-wounded Turkish veterans also deny the disability categorisation, as they indicated people with disabilities were born disabled and stigmatised objects of charity (Aciksoz, 2012). Another example is found in Lebanese ex-forces injured in warfare; they discern themselves from war-wounded civilians (Hartley, 2013). The Lebanese veterans view themselves as having heroism, bravery, and a privileged status that fellow Lebanese citizens do not merit. This differentiated status creates a sense of meaningfulness for the Lebanese veterans, as it carries with it a masculine and privileged societal position because the injury is from military service and protecting the country. Additionally, Berghs’ (2008) research with war

amputees in Sierra Leone found that 'Amputees rejected any notion of themselves as disabled' because the cultural belief is that 'disability is understood as caused by witchcraft and voodoo' or that persons with disabilities were spies during the war (p. 86). The category or label of being disabled can create stigmatisation.

Santuzzi and Waltz (2016) specify that 'Social labelling effects on persons with disabilities might be buffered or magnified by their personal psychological reactions to labelling experiences' (p. 114). Participants rarely mentioned the term 'disabled' (and I intentionally did not write it into any questions or prompts on the interview schedule because I did not want to influence their narratives). Participant narratives expose a particularly complex space between abled and disabled. For example, Lee (leg amputee) stated, *'[T]his sounds like a cliché and I don't mean to come across as a cliché but being disabled doesn't define who you are.'* Several participants adamantly claim they are not disabled *now* but they *were* disabled during rehabilitation and recovery. Andy (leg amputee) *'threw [his] wheelchair'* away because he *'hated the feeling of being disabled'*. Other participants, particularly leg amputees, spoke of themselves as still abled, with what seemed to be casual mentions of disability. We turn now to the instances when several participants 'othered' their body.

'Othering': how participants 'other' their past and/or their body

Understanding the daily experiences of injury also means we must look deeper, past a biomedical model and examples of defiance, to the ex-service person experiencing their physically-altered body 'that is occasioned by transformations residing in a sensate moving soldier acting in a here and now that is itself transformed by a violence of a there and then' (Wool, 2015, p. 132). This idea that the violence can reside within us means that it can resurface in ways such as post-traumatic stress, or, if possible, the person can move beyond it by placing the occurrence 'in the past'. For example, Seidler explores the idea that instead of 'othering' people we can 'other' our

own bodies or our past: 'Rather the past becomes "other" and we learn not to dwell upon it as we learn to "put the past behind us"' (2013, p. 229). This is a way of accepting what has happened to the injured veterans and to move on in their lives, even if they are unsure what they are looking or moving forward to in their future. Looking forward means finding a new path—one that might not be apparent at times, or at all. Andy suggests injured veterans should move away from the various military charities that have activities on offer in order to 'close that chapter' in their life:

But there also needs to be a point when then you step away from it [the charity organisations]. I think you need to, then, come away from it and start living your life again. And, kind of, close that chapter. You know, it's still part of the book and you can still revisit it every now and again but get away from it and do that. (..) You need to go and make your own way. (Andy)

What Andy describes is also illustrative of his independence, by explicitly stating one needs to 'make your own way' by not being dependent on the charities for lots of different aspects of life, such as trips and gatherings. This portion of his narrative was more about injury and rehabilitation being a 'chapter' that does not spill into the next one. As he specifically mentioned, 'I had eighteen months of being disabled.' He was speaking about the time between his injuries whilst on operations to the time he decided to have his lower leg amputated. Andy's narrative is one that gave me pause. It did so because he would tell me one thing whilst his body indicated another, such as saying he was fine but demonstrating a facial grimace upon standing when we were departing the café following the interview. Charon (2006) calls this involuntary embodied reaction a part of a 'corporeal gap' (p. 90). This gap is a form of 'othering' the body, as 'the act of telling separates momentarily, the teller-who-reports from the body-that-feels' (Charon, 2006, p. 90). Even though Andy experienced an elective amputation and claimed it was an improvement compared to his previous debilitating leg, his body hurt when he stood up, taking a few minutes to function after we finished speaking and were preparing to depart the cafe. In narrative instances, both Andy and Paul spoke of their injured legs in way that 'othered' their former limb. Andy said:

I almost kind of had two separate recoveries. You know, one was trying to cope with the [damaged] leg and then the second one was, was getting rid of the leg. (Andy)

Like Andy, Paul was given the opportunity of salvaging his damaged leg and going through rehabilitation. He did so, but had this reflection with regard to having done it differently:

In hindsight, I would've cut it off in hospital and just had done with it, cuz I would be three years down the line now. But if I hadn't had all of these surgeries, I wouldn't have known it was the best thing cuz I suppose if I'd just had it cut off, I'd always wondered 'What if?' But I'm sort of glad in a way that I exhausted all opportunities and all options so that when I cut it off, I knew it was the right decision. And, yeah, it's fine now. (Paul)

Paul's statement reflects the difficulties some participants faced when their limb had been salvaged by medical teams, living through multiple surgeries to make it function again, only to live with excruciating pain and a limb that does not 'work'. Both Andy's and Paul's initial experience were of being 'anchored' until having an elective amputation, which moves them into the 'adapted' category as they can be mobile every day.

In the following case, J.P.'s experience further highlights the 'anchored' category, as he is in that 'grey area'; he currently has his leg, but it causes him severe pain every day along with very limited daily physical ability. J.P. has been told by the medical doctors that an amputation of his injured leg may be imminent, and he stated the following about his leg:

So, I was given a choice at the start: 'We can either chop it off now and you can have a prosthetic, or we can try and save the foot and do some stuff with it...' So, I chose to save the foot and it's working, it's working out so far. (J.P.)

Whilst not overtly obvious when participants told me their stories, these phrases, and using the term 'it' when referring to their post-injury legs, did become evident to me later whilst analysing the transcripts. Some participants distanced themselves from their limbs in order to make the choice of an elective amputation easier; both Andy and Paul mentioned how difficult it was to

ultimately choose to have a leg amputated. J.P. is still in the negotiating time period of assessing the pain of keeping his leg versus the loss of his leg, which might bring the end to the daily pain.

Masquerade

One way of telling the story about living with prosthetics was through ‘masquerading’. Some participants seem to defy the desire to hide their prosthetics and do not try to hide the injury. Siebers (2008) defines masquerade as a concept that ‘claims disability as a version of itself rather than simply concealing it from view’ (p. 101). Goffman (1963) used the concept of masquerade as a form of ‘stigma management’ for a ‘discredited’ person (p. 97). In other words, participants willingly put their injury on display through the visually obvious prosthetics and accept strangers asking them questions. For example, Dave stated it is helpful to him if people are aware that he has prosthetics, *‘Most of the time in prosthetics I wear shorts so people can see that I have a disability and [they] are generally very considerate of that.’*

Some participants reported exhibiting their prosthetics, some with tattoo-like features that had been incorporated into the socket design by the prosthetist. In fact, several participants reported visually exhibiting their prosthetics almost daily. This approach to having prosthetics ‘on display’ can be described as ‘new perspective’ and a positive way of coping (Epstein, Heinemann, & McFarland, 2010; Brewin, Garnett, & Andrews, 2011). Lee said:

I say I don't want to be defined by my disability, but I wear shorts all the time. Um, and I'm okay with that. Kids see my leg and they wanna come and they point out to their dads, and they're like, "Oh, don't pester! So sorry!" I say "Oh, that's alright! Don't...they're kids!" It don't bother me. So, I don't know. I'm not ashamed. I'm not ashamed of it, which is not the same as not wanting to be...it's not mutually exclusive from not wanting to be defined by it. (Lee)

Other participants are like Andy, who do more than display their prosthetics but use them to gain attention or for amusement when with friends. Andy stated that he learned to *‘Embrace your diversity, embrace your differences. Now, I've got loads of party tricks where I can take the leg off*

and drink beer out of the leg. I can do a headstand and drink a pint of beer on my head!' This behaviour, according to Boster (2013, p. 73), is when 'Individuals may 'perform' disability to adjust or control how observers react to them in certain situations'.

In this instance, Andy is choosing to 'perform' his current identity by 'exaggerating' his physical differences (Siebers, 2008), which can be related to, but not the same as, his previous performances of a military identity (Woodward & Jenkins, 2011). Andy referred to the rehabilitation time spent with other injured military personnel and exclaimed, *'You learn all these[tricks] ... like putting your leg on backwards and walking around and stuff!'* Andy is undaunted by people staring, commenting, or interacting with him whilst he has his prosthetic leg visible. Mark, too, stated that he is comfortable with his prosthetic legs and arm visible, as he *'walks around all day in shorts and a tee shirt.'* Mark then said to me *'If I was able-bodied and maybe you were an amputee and you were walking around with your limb on show, my first thought would be, 'She's obviously comfortable with it or she wouldn't be showing it.'*' Similar to Lee and Andy, Mark welcomes conversations about the prosthetics he uses every day.

Passing

Other participants' narratives emphasised the importance of passing. Passing is the opposite of masquerade; it is the attempt to appear outwardly to society as an able-bodied person, or as 'normal'. Brune and Wilson (2013, p. 4) contend there is power in defining normal able-bodiedness and people can 'lose rights and privileges when they are labelled deviant'. In other words, when they are labelled 'disabled' their social status might be negatively impacted (Sørensen, 2015). As mentioned in previous chapters, prior to injury, participants were in a privileged, able-bodied, heteronormative position (or status) whilst in the armed forces. Therefore, an option is to 'socially distance' oneself from people who are 'genuinely disabled' (Deal, 2003, pp. 898-900) by passing.

Passing allows the concealment of a physical disability from societal on-lookers because it 'is an act the blurs the lines between disability and normality' (Brune & Wilson, 2013, p. 2), 'concealing [the] disability from discovery' (Siebers, 2008, p. 100), and 'where the stigma [in this case, the injury] is nicely invisible and known only to the person who possesses it, who tells no one' (Goffman, 1963, p. 73). For example, a person with a prosthetic leg wearing trousers (that cover the prosthetic) and walks without a noticeable limp can 'pass' as someone without a disability. 'Passing is possible not only because people have sufficient genius to disguise their [disabled] identity but also because society has a general tendency to repress the complex embodiment of difference' (Siebers, 2008, p. 100). What Siebers is claiming is that society prefers to not have to acknowledge physical differences, that it is easier and preferable for other people to appear 'normal'. Some participants referred to having an injury that is not immediately seen, which allowed them some flexibility to 'pass'. Specifically, Pav, with his spinal cord injury, stated, *'It's an invisible injury. You can't see (..) cuz you don't see that impairment.'* He felt that he could pass as normal on the days that he did not need his stick to walk. This ability to pass as normal also allows the veteran to 'mute' their injury, even if only temporarily.

The 'cultural imperative of normalcy', Kinder (2015) argues, applies to injured veterans' assimilation back into society. This imperative is supported by participant narratives stating how important returning to 'normal' is, mainly focussed upon the physical ability to walk. To stress the importance of the attainment of post-injury walking, Oliver (1996, p. 104) asserts:

Rehabilitation constructs the concept of walking uncritically in that it is never analysed or discussed except in technical terms – what surgical operations can we perform, what aids can we provide and what practices can we use to restore the function of walking? Walking is more complex and complicated than that, both as a physical act and indeed, a social symbol.

Further, the 'Amputee Patient Care Program' for wounded US veterans has a 'guiding principle' that 'patients come as close as possible to their preinjury level of functioning' (Messinger, 2010, p. 288). Returning to preinjury functioning is what my participants believed and articulated as

‘normal’. In the case of Mark, he stated upon his return from a prosthetics ‘boot camp’ in America that he *‘started living a normal life and normal day’* and that he tries to *‘hit everything with the philosophy of just use normal stuff’*. He feels *‘motivated’* and *‘empowered’* because he can use his prosthetic legs full-time and can drive a non-adapted car. This idea of what is normal is reflected in Waldschmidt’s (2005, p. 192) argument, ‘Normality is concomitant with ‘deviation’, which will always be produced so long as people with and without disabilities strive for normality and a life in the heart of society’. Whilst their appearance may deviate from a ‘normal’ abled body, participants described how they achieved a new form of normality, which is based on their previous ‘normal’ (Cogan, Devore, Haines, Lepore, & Ryan, 2017).

For example, Jon (triple amputee) explained that he is *‘wheelchair free’* and that he liked *‘being able to talk to people properly because you’re not looking up their nose.’* Paul stated he hated being in a wheelchair and described how it felt putting on his prosthetic leg for the first time, emphasising that *‘being tall’* and wanting to run were immediate. He also mentioned that his prosthetic leg is *‘better than the leg I had’*, meaning the damaged leg he was living with prior to elective amputation. Lee stated that when he first had his prosthetic it was:

Amazing! Standing up again! (..) It was extremely emotional (..) Every day away from injury is you’re a day better, a day stronger, a day more mobile...a day more independent...getting back to the person you was [sic]. (Lee)

For several participants, being mobile was their physical independence finally achieved after spending time using crutches, sticks, walking frames, or wheelchairs. Andy stated he just wanted to do *‘normal things’* after his amputation. He wanted to be:

[S]ocialising normal with family, going for a beer with me mates, a big football fan (..) literally just doing all the things that I enjoyed doing beforehand [before injury]. Just doing them a little bit differently now, with one leg, really! (Andy)

Having a prosthetic leg enables Andy more than a wheelchair did and ensured Andy was able to accept his elective amputation. In Siebers' (2008) terms, there is a 'different conception of himself, one not based on the past but on the present and the future' (p. 27).

Another participant, J.P., said that with a brace he can '*walk normally. You wouldn't know anything was wrong with me.*' But just a few minutes later in our conversation, J.P. stated he does not like it when he wears shorts and people ask about the brace or his leg. He said he '*shuts 'em down*' because he '*doesn't want to talk about it.*' This type of passing-as-normal might 'take a psychological toll and can also reinforce—or, at least, fail to challenge—the stigma of disability' (Brune & Wilson, 2013, p. 4). J.P.'s able-bodied appearance is thus always under negotiation because he does not like the attention his leg brace causes whilst he is in public spaces.

Some participants had a narrative dissonance about normality, which conflicted with the fact that their injured bodies limit how active they are able to be on a daily basis. For example, Colin, with neck and back injuries, spoke about the necessity of using a spinal mobiliser for fifteen minutes each morning to retain being active each day without the use of a stick. '*That's all I need to do on it and that allows me to lead, physically, a relatively normal life*', stated Colin. His injuries cause him great pain each day and so the use of the mobiliser eases a small amount of the pain, ensuring he can get up, leave his home, and participate in activities or volunteer. If he does not use the mobiliser every day, his injuries prevent his being fully mobile without an assistive device (stick). Pav also mentioned a '*preventative measure*' by doing '*mobility exercises every day that I have continued from Headley Court.*' Pav often uses a stick to assist in walking.

Bodily limits and limitations

Conditional corporeality

Participants' bodies were narrated as no longer being stable but rather having become constantly mutable entities, where physical over-use or pain could temporarily alter the ability to

continue being independent. It is for these reasons that I introduce the concept of 'conditional corporeality' wherein participants narratives highlight the probability of 'over using' their bodies or pushing the body past its physical limitations, thus experiencing a physical setback. For example, as participant Jon stated in Chapter Five, by wearing prosthetics for too long, one can get sores or lesions on the residual limb, followed by infections, which could lead to hospitalisation (or surgeries). Pain, too, can be incapacitating at times, for amputees and other participants with spinal cord injuries.

Achieving complete independence can be hard, if not impossible, to obtain for several reasons: prosthetic maintenance time, weight issues, electricity dependence, pain, and post-injury physical complications. Andy's reality is, that if he needs an appointment for his prosthetics, he must take at least three hours out of a day to visit a Murrison's Veteran Centre. Dave, a double leg amputee, further illuminated challenges in life with his prosthetics:

[O]utside of the functional frustrations, they are painful. They're heavy. They're hot. You can be uncomfortable sat down. You can be uncomfortable stood up. You, basically whatever position you are in whilst wearing prosthetics will become uncomfortable very quickly. So, you have to keep switching positions. They break. They need constant maintenance, which requires trips to the prosthetics centre, which then impacts your ability to just live a normal life. (Dave)

Dave's last sentence about impacting an '*ability to just live a normal life*' is precisely what is missing from a medical review of his rehabilitation. The need to arrange his life around regular maintenance, in addition to the occurrence of his prosthetic legs 'breaking', suggests that he is living with a reality that encompasses the possibility of inconvenience and dependence on the assurance that his legs will function when needed.

Knowing one's life can be disrupted due to 'maintenance' is indicative that one is not, from a social and welfare context, fully 'independent' or physically autonomous. It appears to be the 'paradox of prosthetics', wherein they are able to function independently for a time but not *all* the

time. The reality is that many participants live with a *conditional corporeality* and their ability to be independent can be altered at any moment. Lives are complicated due to the need to *'plan days the night before (..) because things are now a little more difficult and I'm a bit slower'* (Mark).

Focusing on the functionality of an amputee does not account for weight loss or gain, which prevents prosthetics from fitting correctly onto one's residual leg. This change renders the prosthetic useless for the time being, as it will either slip (because the leg stump is too small because of weight loss) or not go on (because the leg stump is too wide due to weight gain). Also, to note is the need to literally 'plug in' and charge the micro-processing knees for above-knee amputees who use them. As triple amputee Mark explained, *'[Y]ou plug 'em into the wall; charge 'em up. Takes you (..) six hours for a full charge and you can get six days out of 'em'*. Other issues are the pain or actual physical problems that can—and do—keep amputees from being able to work in many full-time positions. Wool (2015, p. 43) calls these problems 'setbacks and detours', which begin during recovery but will last far longer during their life. For example, Jon, another triple amputee, experienced multiple surgeries several years post-injury when he was diagnosed with heterotopic ossification, which is an unexplained, rapid bone growth on the amputated bone site (Shehab, Elgazzar, & Collier, 2002). The following is an example of the 'slippage' found between 'adapted' (wheelchair free) and 'anchored' (multiple surgeries). Jon stated:

I'd been wheelchair free for over three and half years and then, all of a sudden, I had a bone growth in my right leg that was causing wounds and getting infected. As a result of that, I started down the path of surgeries. Ended up being fifteen surgeries over the last two years. (Jon)

Jon's surgeries were done attempting to correct the current problem (bone growth) as well as prevent future problems by *'transferring full thickness skin with all the 'plumbing'* so that circulation in his leg would also improve. His fifteen surgeries over a twenty-four-month period left little time for anything but rest and recovery between surgeries. It is precisely this lack of independent mobility and continual battle against further post-injury complications that are the

principal reasons for a medical discharge from the military, which is discussed in the previous chapter. It is also during these times that carers are needed for the injured veteran.

Depending on carers the majority of the time is another issue. The participants want to be as physically autonomous as possible, since they were physically able-bodied prior to injury, but find themselves 'anchored'. "Care" is the opposite of what they [the participants] want from government policy or service providers, and misrepresents what people need to live independently in the community' (Barnes & Mercer, 2003, p. 38). Ken, a participant who uses a wheelchair full-time due to his extensive injuries, discussed the effect of multiple surgeries, needing his spouse as a carer, and how it negatively impacted her career. Ken did not use prosthetics due to the severity of his leg injuries (he mentioned not having long enough residual limbs as well as lacking autonomy to put on prosthetics due to a lack of fingers). Ken continually experienced infections and skin shearing when having surgery on one leg, which prevented moving forward with the possibility of having prosthetics properly fitted or worn. He stated that his care is frustrating because it is *'not managed very efficiently (...) and it doesn't just impact me. It impacts (his wife) as well.'* As Hyde (2016) notes, the 'messy spatio-temporalities of militarisation' are also 'inhabited by women married to servicemen' (p. 864).

As Ken's carer, his wife is—and will continue to be—impacted due to his military service. Where she would have previously been in a state of 'readiness' for his deployments, moves, or other related issues, Hyde asserts there is an 'emotional contingency' tied to this particular 'messy' space and time (2016, p. 864). Ken further explained that various inflictions prevent prostheses use for veterans, *'Not all can get on with prosthetics due to spinal injuries, head injuries, and extensive damage to nerve endings.'* Ken's reality, like others who were injured by explosions in war, is that his body may not be capable of being independent again, thus placing him within the 'anchored' category.

In addition to a lack of independence, physical issues can worsen over time as the ‘anchored’ example below attests. For example, Pav stated that once his physical care transferred to the NHS system, his bodily status deteriorated. His physical mobility relied on frequent, effective healthcare, which he felt he did not receive once he was discharged and on his own:

But actually when you're discharged and you don't have access to that military rehabilitation service, and you're in the loop of trying to get a physio through the NHS, where you can get a 20 minute appointment once every six weeks, and you don't really achieve anything in 20 minutes. You end up realising, your level in life is about 30% and not 80. And it's a vast difference but you do realise you can't have that intensive physio all the time. (Pav)

Pav went on to say that after the medical discharge, both his rehabilitative experiences and physical ability declined, ‘*But I think it's a bit of a false illusion that you get out at that level and once you've lost that support, your condition drops...vastly.*’ Pav’s experience highlights the necessity of continued civilian-provided care at a level equal to what is received whilst serving in the military.

Participants with limb loss will have decades more in life of being an amputee; they will not be the young and relatively fit person who left the rehabilitation centre. Their bodies will deteriorate, as all ageing bodies do, except their body will experience more demands—on their joints, their muscles, etc., due to the physical loss—in addition to other general military service experiences, which cause biomedical issues (Hinojosa, Sberna Hinojosa, & Ngyuen, 2017; Bollinger, et al., 2015). As Mark stated, ‘*I (worry) with my hips and stuff. But I take the right supplements. I live a healthy lifestyle cuz I wanna be walking around on these as much as I can for as long as I can.*’ Mark’s comment hints at the time when he will no longer have the option of using prosthetics but will need another form of mobile assistance—a wheelchair.

Further, J.P., who experiences incapacitating pain, indicated that he was told that he might have to go through the process of rehabilitation again when he is older:

Further down the line...(.) I've been told by the doctors who've done it as well but, it's [the pain] only gonna get worse...and.. It might be 5 years, it might be 10...but...eventually, it'll get a little too painful and then they said, it might have to come off. (J.P.)

Body rationing

Several participants enlightened me by telling about their experiences of rationing the use of their body. This 'rationing' was a daily activity for some participants that must be carefully factored into how they planned their days or week because overextending themselves had severe physical repercussions. Other participants acknowledged that they tended to strain their physical threshold due to their military background. This behaviour is similar to the research done with US veterans (Cogan, Haines, & Devore, 2019) and other groups whose livelihood was dependent upon their bodies, such as dancers who will 'push through pain' despite being injured (Rivera, Alexander, Nehrenz, & Fields, 2012, p. 9). Below, Pav describes 'conservatively managing' his spinal cord injury:

I am trying to do that best I can at conservatively managing the problem. I've learned to...slow it down. (..) So, instead of smashing into it, I actually said "Look, this training programme - I'm not gonna be able to do because I need to do lighter weights, build up a bit more slowly, so I get confidence" and I have been able to uh, be honest with myself that by striving to do this Invictus, it was about not doing it to the point where I broke myself this time. Because there is nobody there to fix me now, I'm not a part of that system. (Pav)

The Invictus Games allow WIS and veterans to participate in a sporting competition with international teams, highlighting what Cree and Caddick (2019, p. 11) refer to as the 'warrior body', and competitors who perform in the games to 'push their bodies to the limits and show their more-than-human capacity to "overcome"'. Whilst Pav had 'performed' in a previous Invictus Games, he acknowledged this current Invictus preparation would test his body to the limits. Pav mentioned he was only doing the things that would not harm his back to the point of being 'broken'. As Cree and Caddick argue, this public display of the 'wounded military body' (2019, p.

3) in *Invictus* replaces the battlefield with a sporting arena (p. 11) to prove the injured men and women have 'triumph[ed] over adversity' (p. 12). However, as Pav states, he cannot afford to 'break' his body 'because there is nobody there to fix me now'. Knowing that if he re-injures himself, Pav would not have the instant, 24-hour care previously provided by the military means he must continually negotiate how much he pushes his body's physicality.

The quotes below from A.D. and J.P. both illuminate the information that place them within the 'anchored' category due to necessary physical 'rationing'. Following his traumatic brain injury diagnosis, A.D. knew he had limited physical and cognitive time each day. A few years after A.D. left the armed forces, he wanted to volunteer in his local community as a Magistrate; unfortunately, he discovered he could only perform his court duties a couple of times per month. A.D. must physically prepare before and recuperate after the one day in court:

But it takes, like for a one day sitting, in court, it's four days, minimum, it costs me. To not know but to know as much as I can, that I won't have a seizure in court, means that I basically sleep for 48 hours before (two days) for about twenty hours a day for both of those days. (A.D.)

Similarly, J.P. also approaches his physical activities with the reality that there will be a toll afterwards. He knows that all of his days are a form of 'cost-benefit' analysis where he must judge the cost (pain) versus the benefit (socialising and being active). J.P. explained:

I can do quite a lot today. So then, say I've got eight hours today and I'm quite active. Tomorrow, I'll only have three hours cuz, the leg is...swells up. And it starts hurting around this bit, actually (not sure where he pointed...). And uh, it also swells into the carbon fibre well, casing. So, that starts aching but after that, I... I've just got to take the brace off and elevate the foot and get a bit of massage going. But, yeah... If I do a lot today, I won't be able to do a much tomorrow. If that makes sense? It swells up a lot quicker. (J.P.)

I asked J.P. if he could rest throughout the day if he knew he needed to be quite busy or if he simply had a certain number of hours per day, he could be active. J.P. replied, ensuring I understood that he did not want to, as he defined it, 'burn it out':

I try and do less beforehand. If that makes sense. Whereas if I'm doing a lot for consecutive days (..) I'll just go and sit down, and I won't be able to do ought else. But it is what it is. (..) It's more of a "if it starts hurting, I'll just stop doing anything". I think that factors in - what I do, cuz I tend to do a lot less than what I used to do, nowadays. Purely for the fact that I don't want to 'burn it out' if that makes sense? So, I tend to do less.... (J.P.).

He further explained more of what the future holds in store for him. J.P.'s medical consultants had prepared him for the possible loss of the lower leg once the pain becomes too amplified for daily coping. This reality means going through surgery and rehabilitation again, but when much older:

[B]y the time it gets too painful to walk on, I think I'll be in a wheelchair by that stage. But I think I'd rather...cuz if I do have it off, I'm basically gonna have to start all over again... like the whole process again of going, getting a prosthetic. Going to rehab to use it. It's like when it happened, I was fairly fit and healthy, so the healing process - it didn't take long. My foot healed quite quickly, to be honest but I don't know if I could go through it again cuz I don't have the same mentality anymore. But if it comes to a choice of being able to walk with a prosthetic after another two years of rehab or wheelchair bound for the rest of my life, I think I'd rather go for it again... But Uh.... I'm not at that stage yet. Don't know how long it will be...but...it might be 10 years from now. I don't know. (J.P.)

J.P.'s chaotic future was playing out in his narrative so that I could understand the issues of his 'now' will also be issues of 'later'. Both his body ('I was fit') and his identity ('I don't have the same mentality anymore') are in conflict with who he used to be. For other participants, they acknowledged their 'military' mentality had stayed the same, however, when applied to their post-injury bodies it becomes an issue. A.D. stated:

[You'll] have seen with military (..) they (the armed forces' basic training programme) break you down, build you up, and they've obviously selected you also to have drive and stubbornness and self-discipline and motivation...and it doesn't matter how shit it gets, keep going! If it's shit, move on so there's less shit...or at least the shit's different. Do not give up!! End of story. You don't give up! That's great. It helps you win wars. It helps you stay alive and helps you keep buddies alive... Not so great with brain injury and other things in that, sometimes, you've got to stop. Brain injury, or my brain injury anyway, a lot of the time I've got to stop. But what's fighting that is 'Do not give up. Do not give up. Do not give up under any circumstances!' (A.D.)

The past training of ‘carrying on’ through difficult situations (Higate, 2003) was also referenced by Colin as something that was difficult to navigate with bodily limitations. While Colin is typically in the ‘adapted’ category, he regularly ‘slips’ into the ‘anchored’ category when he physically overexerts himself. Colin spoke of a ‘boom and bust’ cycle approach, which was a leftover element of being in the military:

[B]eing prone to boom and bust, um, I'm quite adept at dealing with the acute stuff now. Um because I accept that's just part of how I am, as much as somebody can tell you that you shouldn't do that, there's a part of you that's always going to want to do that, um, because it's that feeling of being normal. You know, whether it's walking a dog for 3 or 4 miles instead of just walking it for a mile... I think it's pretty natural to most people to wanna do more than they probably should, but particularly for a service person, I think. (Colin)

I asked Colin to explain to me how he defined the phrase ‘boom or bust’. He expounded, stating that it is pushing himself until he possibly physically ‘breaks’ or becomes incapacitated:

Yeah, I will...if I'm given a task, whether it's physical or...I will commit to it 100% even if I break myself. So, I boom and then I bust...and that's, that's kind of a cyclical thing that I go through. (..) I think it was, maybe common, particularly in service personnel that you don't want to be seen as being physically weak. (..) [I]t was learning to understand that, do less each day rather than doing loads on one day and being kaput for the next three or four days. Um, and so that's, that's what I learned. I'm still prone to boom and bust, though. (Colin)

It is not unusual for the participants to continue this type of cycle that Colin mentions. Due to their embodied past, former service personnel do not wish to be seen—or view themselves—as weak, which can be problematic as they attempt to push their bodies beyond current physical capabilities (Csordas, 1993; Higate, 2003; Carless & Douglas, 2017; Basham, 2013; Hockey, 2013; MacLeish, 2013; Bulmer & Eichler, 2017).

Conclusion

In this chapter, participants’ stories focussed upon the traumatic aftereffects of becoming disabled. The social construction and implications of disability were introduced to assist in placing the participants’ narratives in a lived, embodied context. I presented new narrative typologies of

‘anchored’, ‘adapted’, and ‘ascending’. The ‘anchored’ narrative is one of limited physical functioning with daily, sometime incapacitating pain. The second narrative type of ‘adapted’ are those who experience physical daily functioning with varying levels of pain. Finally, the third narrative is ‘ascending’, wherein participants have a high level of daily functioning with little to no pain. Whilst the majority of the participants reject the label ‘disabled’, their narratives highlight the difficulty of having an impairment and remaining independent in daily life. Some participants ‘othered’ their bodies and past self. A few participants narrated a type of defiance of disability by ‘masquerading’ and publicly displaying their prosthetics. Many participants simply wanted to ‘pass’ and ‘get on with it’ so as to not indicate ‘anything was wrong’ with them. The majority of participants focussed upon wanting life to ‘be normal’ and told about activities they are capable of doing, thus the dominant theme of physical independence. However, I argue that this narrative is a temporary one, as an injured body is not a static way of being. Participants’ stories demonstrate this tenuous space between able-bodied and disability, which I refer to as a ‘conditional corporeality’ due to the need for rationing their bodily use each day. Lastly, the concept of ‘body rationing’ is introduced, showing how some participants must constantly ‘ration’ their daily physical actions.

Chapter 8: Narratives of Making Meaning of Life and Looking to the Future

Introduction

In the last chapter, we ended with the bodily rationing and the narrative typologies of physical independence. This final empirical chapter investigates participants' lives with regard to work or volunteering, family, sport, and university education. Physical limitations play a part in the levels of activeness for the ex-service members every day. Variation in their daily activities appealed to most of the participants and this reflected what some stated they liked about their time in military service—that there was, as J.P. said, *'Always something to keep you excited'*. This chapter will focus on commonalities within participant narratives about their current daily happenings and their futures. The dominant theme was continuing to 'serve' and having a purpose, albeit in new ways. The participants are employed, volunteering, teaching, attending university, and fundraising for charities. A subtheme about setting goals also emerged. Finally, narratives about the future are discussed. These narratives included themes based upon concerns—bodily limitations, finances, and fellow injured veterans. The chapter ends on a note of hope, focussed upon what participants say about their aims for the future.

Narratives of continuity

When the life course is disrupted, the person may experience a 'role discontinuity' (Wolpert, 2000). Atchley (1989) asserts that continuity is subjective and 'an attempt to preserve and maintain existing internal and external structures' and people 'prefer to accomplish this

objective by using continuity (i.e., applying familiar strategies in familiar arenas of life)' (p. 183). As Nimrod and Kleiber (2007, p. 2) state:

Internal continuity is the continuity of different psychological characteristics, mainly the 'self' (what we think about ourselves) and 'identity' (those aspects of the self that people regard as constant, regardless of social situations). *External continuity* embodies the roles and activities of the physical; and social environment. (Italics in original)

Caddick et al. (2018, p. 28) suggest that some veterans with limb loss can 'struggle to adapt' as they age, which could include a 'loss of continuity (e.g. continuity of self-image, bodily capability and masculine potency)'. Further, this loss can 'give rise to transient or more permanent feelings of despair' (Caddick, McGill, Greaves, & Kiernan, 2018, p. 28).

Faced with discontinuity, participants look for a way to find connections with their past. Role salience, or 'role attachment', according to Loder and Spillane (2005), 'refers to subjective aspects of the role such as the sense of competence and self-worth that the role brings to the individual. In this sense, an individual is "attached" to a role because it resonates with his or her sense of self' (p. 266). This conceptual framework emphasising continuity can be applied to veterans who were injured, discharged, and are experiencing a 'retirement' that was previously unimaginable. I found participants have—or still are—reconstructing it all (the body, the life story, and a purpose) in order to give themselves continuity.

During several of the interviews it became apparent that the idea of continuing to 'serve' others, having a sense of purpose, or goal setting was important to the participants. Many participants articulated a continuation of public service, whether through work or volunteering roles. Green (2014) contends, 'When British Service personnel experience a dramatic change in life-course, loss of physical ability often has a significant (negative) impact not only upon their levels of self-esteem and self-confidence but also on their sense of life meaning and purpose' (p. 144).

Wool (2017) claims this space of physical inability and its negative impact is the ‘fragmented stuff’ of life, where ‘both a world and a body’ are fractured for injured service members in the US (p.79). Brockmeier (2000) refers to a ‘fragmentary model’ of life narratives, wherein narratives can be ‘told under the explicit premise of breaking with coherent and linear story lines that are associated with outdated “grand narratives” of life’ (p. 69). These story lines are presented as being a narrative choice by Brockmeier, as he asserts this style is used by ‘younger, educated, and urban people [who] are often driven by the attempt to avoid presenting one’s life in traditional developmental genres’ (2000, p. 69). Due to their career-ending injuries, however, my participants do not have the choice of their life stories breaking from a ‘traditional developmental genre’ and the fragmentary narrative surfaced whilst they spoke. Participants undertake narrative ‘reconstruction’ and bring a ‘sense of order from the fragmentation’ caused by their traumatic injury (Williams, 2004, p. 249). Participants do so by finding something in their lives that will at least partially recreate and reconnect them to their former ‘serving’ self.

Goal setting

A way that participants stay connected to their former self is by goal setting. According to Finley (2011), veterans with a traumatic past can have success with targets: ‘Little by little, they work toward goals they have set for themselves’ (p. 151). This form of continuity helped participants stay motivated. For example, Andy is about ‘*the next thing*’, where he is constantly setting goals—a habit that is a continuation of his identity, particularly regarding his physical ability (Allen Collinson & Hockey, 2007). He told me about some various things he has tried since his injury: wrote poetry, tried skiing, and began running again. Andy thinks goals are vital, as he stated:

Mentally, I think eh, I, I struggle if I've not got a goal. Like I always need to have something. You know, getting into the Marines was a massive goal. And then Iraq, Afghanistan, and then...[after the injury] learning to walk and to run, and then, I then I broke this world record—fastest amputee in the world—and that was... So, I need to have goals. I think if I don't have something to set me [sic] mind to, I think I can go off track a little bit. (Andy)

Andy's need for attaining goals is supported by Brewer et al. (1994), who argue that injured athletes' goal setting can 'enhance [their] psychological well-being' (p. 176). Andy further illuminated that having goals is better for him so he can be more positive with others:

I think I need to keep my mind focused on...whether it's climbing a mountain or swimming the channel or...I don't know, it could be anything. It could be writing poetry. It could be anything, it could be...I need to set a goal all the way towards it otherwise, yeah, I'm not great to be around otherwise. (Andy)

Dave, who is a Paralympian is also a PhD student in engineering. Being active in physical sport and activities is helpful to injured service personnel due to goal attainment (Green, 2014) and mental well-being (Caddick & Smith, 2018). Dave aims to help other amputees and medical professionals by designing better prosthetics:

My PhD work is in biomechanics. So, I'm creating a computational model of amputees, particularly bilateral transfemoral amputees, to monitor their muscle contribution to movement in order to design better prosthetics, better rehabilitations, or better surgical procedures. (Dave)

His goals include designing and creating bespoke, user-friendly prosthetics programme based on his personal experience as a prosthetics user:

The product of my PhD should be a tool which can be used by prosthetists, physios, doctors, engineers. (..) They should be able to use it to design a better programme, whatever the area they're in. (Dave)

Sense of purpose

As Jolly (1996) states, 'Military service is a unique occupation. It is more than a job, not only a profession; *it is a way of life*' (emphasis mine) (p. 2). Feeling the need for purposefulness in daily life cannot be understated for my participants'/veterans' narrative cohesiveness (Ahern, et al., 2015). Some participants found their purpose through serving their community, such as volunteering or teaching. Several are employed, such as Mark. Mark stated that his life needs a

purpose. He mentioned a life-long aversion to a traditional '9 to 5' job, which is why the armed forces were enticing to him. Mark joined the Royal Marines because *'[T]hat's what I liked about the military is the variety (...) no two days are the same.'* His statement below reflects his continual desire to avoid '9 to 5' monotony:

It isn't like what I imagine...what I think in a civilian job is...you get for work at half past eight, you couldn't leave until 5, even if you had nothing to do, you'd be sat there twiddling your thumbs until you had to go at 5 o'clock or half past five because that's what the boss expected. (Mark)

He further highlights what he does not like about the cyclical, predictable nature of the Monday through Friday, '9 to 5' employment:

You come home; you'd have your dinner, do what your evening routine and... you'd just do that Monday to Friday, which is my idea of hell. [T]hat would just kill me...I like a bit of routine every now and again and in certain areas of my life, but I think I thrive more on variety and having a different thing to do every day. (Mark)

To achieve the mix of variety and routine he desired from his past career, Mark has found a new 'embodied continuity' (Higate, 2013), as he is employed full-time by the charity The Royal Marines Association. Mark serves as the Welfare and Operations Assistant. With this job, he travels, networks, lectures, and does some routine deskwork. Mark is also involved in various sport (such as the Invictus Games and Jiu Jitsu), motivational speaking, and fundraising. For many veterans, a sense of purpose is related to their time in the armed forces (Albertson, Banks, & Murray, 2017). As he states below, there is a personal motivation behind all of his activities:

So if I wanted to, I could sit on my ass and do nothing forever. (...) But without a purpose, I think I would just rot. I really struggled to find that purpose. (Mark)

Finding that 'purpose' is part of what makes Mark's present days a positive evolution from wounded service member to who he is today (Bridges, 2009). Mark is committed to aiding other Royal

Marines and their families through the Royal Marine Charity, as well as speaking about the resilience one can have post-injury.

Like Mark, Andy also takes the approach of not working a traditional '9 to 5' job. He referenced his father, a fireman, as a strong influence when Andy was young and looking at what to do with his life:

I think having my dad as a fireman, not really having a normal 9 to 5 job. That probably played the part in my wanting to, you know, not have that - to have the normal boring office job, if you like, and go for something a bit different. (Andy)

Andy decided that he would work part time and trained to be an inspirational speaker, where he is paid to speak about his injury and life afterwards. Participants who get involved with new undertakings are 'innovative' by beginning new activities such as volunteering, intellectual activities (classes or lectures), or creative activities (writing or painting) (Nimrod & Kleiber, 2007, p. 8). For example, J.D. decided to teach part time:

At the moment, I've got two hours of work a week. But that's fine. It gives me something to work at and use the qualifications I've got since I left the Army. [I]t's all people with disabilities, with head injuries, mainly, that I'm teaching...and a few school kids. (J.D.)

Paul decided he would not seek full-time employment after being medically discharged. When asked about what he does each day, his response was:

Now...uh, I am pretty much a man of leisure. I've got my 'fingers in lots of pies'. Um, because even though I had an okay resettlement, from the forces, they kept asking me 'What do you want to do? What do you want to do?' And the only thing I want to do is be a Marine. (Paul)

Paul's lack of complete acceptance of the situation is still palpable, as is commonly found in a military 'retirement' (Schnurr, Lunney, Sengupta, & Sprio, 2005; Kypraiou, et al., 2017). However,

he continued on, reflecting that being a Marine was in his past but that his days are quite full of varied activities of his choosing:

But I can't do that anymore, so I... I'm quite fortunate whereas I've got a pension whereas I don't have to work. So, I do things now that I enjoy rather than something I have to do. (Paul)

Paul mentions different things that captivate his attention and keep him busy:

So, I did a bit of acting, play a lot of golf, just got into motorsport. Um, so yeah, I just got my fingers in lots of pies. My average day is...I'm renovating my house as well, so I'll get up, take the kids to school. Um, probably build until lunchtime. Go out and play golf or...basically do what I want. It's um, quite free. (Paul)

Paul can no longer be what he wants (a Marine) due to such extreme physical damage. He is 'innovative' (Nimrod & Kleiber, 2007) because he is pursuing several new pastimes that interest him such as racing motorcars, fixing his home, and volunteering once a year for charity fundraisers. As Paul indicated, this approach to his post injury life is 'quite free'; he can do as he wishes without worrying about financial issues. This concept of 'freedom' was also expressed by Ken.

Ken told me that he had originally thought he '*must have a job*' in order to fill his days. He continued, explaining it is more about finding something to keep moving forward in life rather than finding paid employment. Ken narrated it as such:

There's a bit more of me coming out that is more of a free spirit, which is, you know, 'You don't have to have a job. Whatever you do, jump forward! Go out!' I've had a tragic thing happen in my life and I know that now that it's all about what you make of life. (..) I retired at thirty-seven years old! (Ken)

Ken's reframing of what he thinks he should do (work) versus what he can do (be a '*free spirit*') indicates that he is still learning to live a new kind of post-injury life. Ken is reforming his sense of self and identity, as he joked about being a young 'retired' man. It is not unusual to experience this 'role change' from being an active duty soldier to retirement-through-discharge. According to

Smith (2004, p. 55), this experience is a role change ‘from paid worker to retiree but also a shift to a person with very few constraints on his or her time’.

Continued service

We turn now to the idea of continuing to serve a greater good – similar to Weber’s idea of a vocation or having ‘a calling’. Weber (2001) writes ‘work hard in your calling’ (p.105); his focus is on the relationship of a Protestant-based work ethic and its impact upon bodies. Weber goes on to say, ‘A man without a calling thus lacks the systemic, methodological character which is, as we have seen demanded by worldly asceticism’ (p. 107). In this sense, the participants indicated their post-injury activities were similar to the continuation of ‘a calling’. For example, descriptions of these activities as having ‘a sense of purpose’ or ‘continuing to serve’; participants do not view themselves as ‘civvies’ (as mentioned in chapter six). They explicitly point out how they continue with physical routines as well as serving others through activities. Jolly (1996, p. 23) suggests this can ‘stem from their lack of close experience of any *alternative* way of life’ (emphasis in original). Participants view their work—their vocation—as a calling, which is instilled during their training and subsequent time spent in the military. Therefore, the desire to continue serving is one effort in maintaining their military identity. For instance, Lee had served in the Royal Marines for over twenty years at the time of his injury. He mentioned what he misses, including friends and adventures; however, he highlighted the need to feel connected to his former self by serving the greater good (Kelty, Kleykamp, & Segal, 2010). Lee stated:

If someone had said to me, "What you gonna miss when you leave the military?" I would have said "it would have been the camaraderie, it would have been the hi jinx, the adventure, the not doing a proper job." So, getting up in the morning, going out in a helicopter that afternoon, and....actually the thing that I miss is the sense of service—the sense of doing something that actually matters. (Lee)

Lee's current civilian life reflects Dima and Skehill's (2011, p. 2534) assertion that the 'starting point for transition is not the new situation, but the ending, the letting go of the old reality and [the] old identity had before the change took place'. Lee, recognising that his future will be different than previously imagined (Walker, 2012), stated how he understands the need to be creative, to not tell 'the same story' forever. Rather than having his narrative caught up in the past (and, perhaps, in the one traumatic event), Lee wants to be ever evolving and have new stories to tell an audience:

Those I know who were injured in Afghan, who are on the talking circuit, they're very much very... 'This one time...in Afghanistan...' and like, ten years later, you're still telling the same story. (Lee)

Lee stated he does not approach his post-discharge life in the fashion of 'telling the same story' but finds unique and challenging physical opportunities for himself. 'Rather than seeing their [amputees] bodies as "defective" or "disgraceful"', argues Berghs (p. 86), amputees can use 'their bodily limitations to access forms of economic, social, and cultural capital' ((Bourdieu, 1986) in Berghs, 2008)). Lee wants to extend his 'marketability' by doing various, creative activities:

So I intend to um, go away, do a daft thing, talk about it, which will mean I don't have to get a proper job, which will allow me to plan the next daft thing, which means I can talk about - start self-perpetuating, is the dream (..) the more you do, the more...more work, is the wrong word...marketability is probably the right word. (Lee)

Lee's approach is to do something 'daft' to promote his ability to 'daft' things, thus creating a pattern of unpredictable predictability. By this, I mean that he will try something new and exciting, give a public lecture at a charity event about it, then build from that interest to plan (and fund) the next new and exciting obstacle. For example, known as the 'Rowing Marine', he is the first amputee to row solo across the Atlantic Ocean in 2019 for fundraising event.⁴² Lee had been part of a team

⁴² Lee's website is: <https://leespencer.co.uk>

to row across in 2016. Having this unusual, extraordinary, record-breaking experience allows Lee another 'daft' thing to tell his audience.

For many years, A.D. was at a loss of what to do with himself, being constrained by the constant possibility of unexpected seizures⁴³, with the additional issue of his inability to process multiple sensory stimuli. He has resumed public service by volunteering as a Magistrate in his local court, which he finds fulfilling. A.D.'s desire to continue serving 'the greater good' is similar to the US veterans in Schrader's research (2019, p. 71), who 'feel they are continuing their service through the promotion of social justice issues'. Unlike Schrader's participants who are fighting the State in their activism against warfare, my participants' forms of service are not directed at stopping conflict or 'fighting' against the State. Below A.D. states what it means for him, both mentally and physically, to serve in court:

But what it did was make me realise there is something out there that is going to challenge me and that I can do. [E]ventually I found it to be a Magistrate, which is part-time enough to, you know, it's a voluntary role, it's part-time enough (...) that I can achieve it but is involved enough that I feel a part of it and feel like you're doing something and giving something back to society. (A.D.)

This volunteer role gives him a sense of service and he knows how his life is ordered whilst serving as a Magistrate:

But that gives me a focus and I, kind of, know where I can geo-spatially place myself in the world. That's what I do now. (A.D.)

A.D.'s current role in society is gratifying to him because he is 'doing something and giving something back to society' and he has a sense of purpose because 'I know where I can geo-spatially

⁴³ A.D. has a history of status epilepticus, a life-threatening situation wherein the seizures repeatedly occur (one immediately after another), causing the need for incubation and hospitalisation.

place myself in the world', even though there is a physical consequence due to the amount of time he must physically and mentally rest before and after court.

Like A.D., many of the participants found that they were able to continue to serve through volunteering. Ahern et al. (2015) call this 'embracing an ambassador role' for veterans. Sometimes volunteering and advocacy work was military-related and other times it reflected the injury experienced. For instance, Andy gave motivational talks to injured Marine recruits (Hunter's Company) at their training centre in Lympstone:

There's a thing called Hunter's Company, where if you get injured in the Marines, you basically tread water while you kind of get better to jump back into training. It's for them, really, to say, 'Look, come get fit, get back on.'
(Andy)

Andy's experiences are not only a way to give back to the Royal Marine community but are also an example of a continued military ethos of determination and resilience. The 'Commando Spirit' is a 'State of Mind' inclusive of the following: courage, determination, unselfishness, and cheerfulness in the face of adversity (Ministry of Defence, n.d.).⁴⁴

It is illuminating that Andy uses phrases such as 'tread water', 'jump back into', and 'get back on' when telling me about the purpose of Hunter Company. These phrases are located within bodily actions, and, for the injured recruits, remain rooted in their physical (in)ability to progress within basic training until—and unless—they are fully physically recovered. Andy's language remains situated in military terms (Higate, 2013; Kinder, 2015). He stated that his identity as a Royal Marine meant he was '*Marine Fit*', '*elite*', and '*led from the front*'. Andy's Royal Marine identity remains, playing an important part in what he says and how he describes himself:

[W]hen someone asks me what I do, whether I say, you know, I was in the Marines, now I do motivational speaking or I say motivational speaking and

⁴⁴ The characteristics of this 'state of mind' were reiterated several times by a Royal Marines officer on my field visit to the Commando Training Centre Royal Marines, Lympstone.

then the Marines, you know, 9 times out of 10 the Marines bit will probably be in that answer, somewhere. (Andy)

Speaking to injured recruits meant Andy used himself as an example of the ability to defeat his physical injury with the ‘proper’ Royal Marines mindset. This ‘mindset’ is instilled into each recruit throughout basic training, which is a lengthy process.⁴⁵ Hale (2008, p. 321) argues, ‘There is a relentless pressure among military personnel to be determined not to give up, succeed and show strength—all of which are masculine qualities’. Andy, injured in warfare, rehabilitated, and running marathons as a single-leg amputee, is the embodiment of the Commando mindset where one could excel with determination. Andy’s narrative is one of a ‘comeback’ (Achter, 2010). The comeback narrative ‘suggests the [veteran] bodies have already been “fixed,” either with prostheses, or by textual and visual strategies that deliver veterans back to a better, more culturally esteemed place’ (Achter, 2010, p. 63).

Others also use their time to ‘give back’ to other charities, specifically military charities. Paul, a former Royal Marine, mentioned his desire to continue helping out his local charities or the Royal Marines Charity each year:

I try to do one thing a year for charity, so I do that. Last year, I cycled 100 miles (..) I like to do a local charity. So that's a Force Cancer charity, which is in Exeter and the Royal Marines Charity, which is obviously close to my heart. I do one thing a year for charity. (Paul)

He continued, telling me about his fund-raising project two years prior:

A year before that was Kilimanjaro, a year before that was Skydiving, and it's getting bigger and bigger... Cuz I want to do more cool stuff, you know. I think the South Pole is going to be next year's jaunt. Just trying to “dot the I's and cross the T's” of getting it going. (Paul)

⁴⁵ At thirty-two (32) weeks, the Royal Marines Basic Training is the longest basic training programme for any military in the world. Accessible at: <https://www.royalnavy.mod.uk/our-organisation/where-we-are/training-establishments/ctcrm-lympstone>

The idea of doing unusual physical activities to raise money for charity was also in Lee's narrative. Prior to his accident, Lee participated in fundraising for the Royal Marines Charity. At the time of his injury, he was preparing for the next fundraising event. The following quote demonstrates how Lee's pre-injury volunteer charity work offered him new possibilities, post-injury, that he had not previously considered:

I was looking to do my next charity event, which was going to see how far I could run in 24 hours was my next thing I was working on when I got injured. So, it's natural... (Lee)

As he was in hospital, he was thinking about what to do, a goal to set:

My first thing, when I was in hospital, within a week, I set myself a goal of raising £10,000 for the Royal Marines Charity in the first year, um, and I done [sic] a sponsored mile walk. Was the first time I walked a mile. (..) I think I raised about £12,000, in the end. So, I had a connection with the Royal Marines Charity. Then they started asking me to talk at various fundraising events. And then Help for Heroes started asking, so I got involved in um, talking, for the charities anyway. And that's how it kind of evolved that way, I think. I didn't wake up and go 'That's gonna be the career for me!' (Lee)

Lee did not imagine that public speaking would be in his future, but the charities asked him. He felt both honoured and obliged to help raise money, so he continues to attend and speak at events.

When asked what activities J.P. had done since discharge, he said that he had volunteered for Blind Vets UK, a military charity organisation:

I volunteered with Blind Veterans UK. I did that for maybe 2, 3 months and I went in and took out this...He must've been about 90. (..) [H]e had dementia, as well as being blind and he had cancer, so he was, he's in a bad way. But he was a nice bloke and he had some really good stories, like, cuz he'd been in the military for donkey's years and he'd done all ... loads of stuff. (J.P.)

J.P. did this as a way to stay connected to his military background, help another veteran, and have an activity to plan. Like the participants above, Colin focuses his time on actively helping others through mentoring fellow veterans:

I'd rather do it as a voluntary thing, um... And the people I coach, it's just been by chance. (..) It's just people who've been friends who've been struggling and they're all veterans. I said 'Look, come over, have a brew and we'll have a chat about it.' (Colin)

J.D.'s weeks currently involve self-care by not overexerting himself, a few hours of paid employment, serving as a carer to his spouse (who has physical issues), and running a support group for others with brain injuries. His involvement with the charity is an example of empathy, a 'deeper understanding and compassion for others', as is found in other research with UK veterans (Brewin, Garnett, & Andrews, 2011, p. 1737). J.D. described his activities:

But my main focus is on supporting my wife so she can stay in her job, um, and the charity that I work with, Headway [the brain injury association]. I do probably about six or seven hours a week for them [as] I run a support group. (J.D.)

It was evident within many participant interviews that they felt a connection to or sense of serving service members, like Andy, or fellow veterans, like Lee and Paul. Or, in J.D.'s situation, assisting others in his local community who experienced a similar type of injury. In many instances, advocacy work is an opportunity for ex-service members to be involved with a military community and helping others whilst doing so or to continue having a 'sense of purpose' and continuing serving society.

Narratives of the future

At the conclusion of our interview, I asked each participant how they envisioned their upcoming days and what hopes or fears they have about their future. I enquired about how they envisioned their near- and long-term futures. Several fears arose for the participants when asked about their future. One worry was finances, either for themselves as providers or for their impending and inescapable bodily needs (such as replacing prosthetics, hearing aids, and other aids). Some anxieties and concerns were politically-focussed. One participant stated concern for

global affairs. Other participants are worried about their fellow injured veterans and the care that they will need over time.

Future fears

Financial concerns

Financial worries were a recurring issue for some participants. One concern was about the financial necessity of regular employment. Lee expressed a fear that he would not be able to continue being a public speaker and his fear was *'[T]hat I can't (continue speaking publicly) and I have to get a proper job!'* Others, with a higher level of physical injury, such as Mark and Jon (triple amputees and daily prosthetic leg users) will need to continue relying upon and replacing prosthetics throughout their lives; they will also need to find funding for replacements. Mark stated that he had been using the same prosthetic legs for several years, which needed replacing:

It's quite a stressful time worrying about the funding. [R]ight now, these (prosthetic legs) need replacing and it's worrying about where that next level of funds is coming from because these are pretty much my life now. (..) I've been ...you know walking around on these now for nine years, full-time. Independently for nine years. So, that is a challenge, um, trying to figure that out. You know and they...they're computers, basically, so they have some of the issues what technology has. (Mark)

Mark mentions his deep concern for the funding to continually pay for his 'legs'. As mentioned in a previous chapter, whilst the funding for veterans exists between the National Health Service and Murrison Veterans Centres, the injured veteran must apply for financial approval each time they need new sockets, legs, or other items (National Health Service England, n.d.). Jon also addressed monetary trepidation. More so, his narrative illuminates the combined unknowns of his future, which are due to military separation, in addition to bodily limitations. Jon's identity as a service person—but also as a father—was evident when he 'was in the Marines' but it is less apparent here:

I worry a bit financially. You know, I need to put my kids through a good education and when I was in the Marines, I could have got huge discounts to put them into boarding school or support to do that. I don't get that now. And I've done the maths and it doesn't look pretty so I need to work pretty hard. Um, so that's a fear. I do fear about my long-term health. I don't know what toll this is going to take on my body... um and part of that then increases the fear about money and stuff in the future, finances, cuz I thinkI'm kind of planning all of my finances around the idea that potentially in ten years' time, I don't know how much work I'll be able to do. I don't know when my body'll just be too knackered or not....um, which increases the amount of pressure I'm putting on myself now. And yeah, and it's just that not knowing bit. (Jon)

Both Mark and Jon's monetary concerns reflect how much it can impact them and their morale (Kim & Moen, 2002), especially for continuing to stay independent and their ability to provide for their families.

When addressing resettlement and other aspects of exiting the military, such as pensions, some of the participants voiced displeasure at the process. Paul described having issues with having his home adapted:

So I was approached in 2015 when I bought my house, by the MoD... um, to say 'Right, because you're an amputee, um, you are entitled to house adaptations to make your life easier. So, accessible pathways around the house, a central pathway around the house, a wet-room downstairs, um, a bathroom upstairs and stuff like that.' (...) so it took over a year to draw up a picture, essentially, and get it put through to planning. And then, I got a letter opened last week saying they're not going to do the work because I've got a 'listed' building, even though they have full planning consent. ... I live in a building site now...(Paul)

Paul's example is one of a sense of being temporally suspended (Wool, 2017) as well as he and his family of five being inconvenienced in their home. As Paul ages, he will eventually need to ensure he can use the ground level of his home, but the MoD rescinded the offer of assistance. It not only affects Paul but his family, too. His sense of frustration surrounded the fact that the work had begun within his home, only to be stopped and left incomplete. At the time of our interview, he was pursuing a situational resolution.

Pav describes the stressful discharge compensation process as being extremely difficult due to being unable to access his military information about the injuries he received whilst deployed.

Here Pav explains his compensation journey as a '*long, convoluted process*':

It's difficult to access support once you're out (of the military). The process is very difficult with compensation and sorting war pension and everything like that. It's not always as easy. Once you're out of the military you're still asked to provide information from the military that you no longer have access to. So, for instance, as part of my pension process, I was asked once, to provide a copy of the logbook from the date that I was blown up in that incident - it would have been written in the logbook. Even though it's on all my medical documentation that was accessed after being blown up, two years after, a year after I was discharged, they wanted me to provide that evidence.

Pav explained to me that this is problematic because he does not have the ability to get the information that is needed for the NHS support. Even though Pav has left the institution that provided his care, there are still barriers to receiving care (Messinger, 2010):

Well, you have no access to that, but nobody explains to ya what you're actually, all your eggs that you need to have in your basket before that release date. And it's very stressful uh, yeah. Very stressful. You think, I need this, and I can't get it. The process isn't easy and it's a long, again a long, convoluted process. I was discharged in 2013 and I've, actually, I'm awaiting a tribunal for my war pension to get the final bit sorted out now. It's been after discharge and I'm still sorting it out. (Pav)

When I asked J.P. questions about his experience surrounding the receipt of military compensation after his medical discharge, he said:

It took a lot longer than the rehab side and that's just created so much more stress than... than the rehab ever did. So, I don't know... I mean, mine...My insurance has literally only just finished...Like, it's only just been finalised. And I've been outside for nearly 2 years...yeah. It takes...That piles up a lot, a lot of stress on top of it all. (J.P.)

He further explained to me:

They give you lump sums, but they'll hold off giving ya your main payment until it's all finalised and they'll always try and go for the lower end even though you know you're entitled to this. So, you've gotta fight for it for a year, like a year, two years...until you get what you're entitled to. So that's only just happened. (J.P.)

J.P.'s compensation was not automatically given to him, and, like others, it was a long process that had to be 'fought' for in order to ensure he received it.⁴⁶

Bodily fears

Mark mentions the psychological toll of determining possible problems and the safest path in public spaces as he discussed a holiday trip:

[W]e're going to Disneyland this year. For me, walking around a theme park, all day is ...will be exhausting. But it's not just physically. It's mentally as well. And I'm, I'm always having to look, you know, at people to see if there's some crazy lady with a pram coming towards me, if there's a big dip in the road. So, things that like... I can't ever, like, go into a, go out shopping and be completely relaxed like I used to. When...cuz I'm always thinking about my legs and then this, that and the other, so.. Sometimes trying to hold a conversation with someone if, if my mind's elsewhere or I'm walking, it's difficult cuz I'm always thinking. (Mark)

Mark expresses the mental and physical tolls he experiences whilst engaging with the world on his two prosthetic legs. Mark hints at but does not explicitly state it, but his words highlight the exhaustion he endures when out in public spaces, where anything—and everything—could cause a fall. Where once his 'somatic mode of attention' (Csordas, 1993) was attuned to dangers in war (Hockey, 2009), now he faces a daily barrage of bodies, items (such as the pram), and spaces that

⁴⁶ From 'Service Leavers Guide', page 31:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/389211/SLG_Dec_2014.pdf

'The Armed Forces Compensation Scheme (AFCS) provides compensation for any injury, illness or death which is caused or made worse by your service on or after 6 April 2005.

There are two main types of AFCS benefits:

(1) Lump Sum Payments: For injury or illness, AFCS provides a tax-free lump sum payment for pain and suffering, the size of which reflects the severity of the injury/illness. Lump sum payments range from £1,200 to £570,000;

(2) Guaranteed Income Payments (GIPs): For those with the most serious injuries and illnesses, AFCS also provides an income stream known as the Guaranteed Income Payment (GIP). This is a tax free, index-linked monthly payment, which is paid after discharge, for life. A number of factors are taken into consideration when calculating the GIP; including lifelong loss of earning in terms of both salary or pension, as well as lost future promotions as a result of the injury.'

must be constantly looked for and avoided. This might seem like a solely embodied experience, but it makes evident that Mark has a new way of seeing and understanding the world, which prevents him from being relaxed whilst away from home, especially whilst he is attempting to be on holiday with his family.

Additionally, participants' narratives reveal the struggle to think of themselves other than self-sufficient and able-bodied is persistent as seen in Pav's idea of his future:

Um, as far as the future, I don't really look um, and I try to take each day as it comes, really, and not... I think in the way of having plans to maybe travel or do something is in regard to my injury.... I was told by the doctors it may deteriorate. It may lead to me being invalided at a young age. So, I try to fight that in my own way - mentally, physically, just doing the best I, best I can, and you know, ultimately, you're the only person that's gonna help. You're the only person that understands but it takes time to learn to ask for help. There's a creation, uh, I don't know if it's shame - it's the wrong word - but asking for help, because you...you know, I'm a 46 year old man now and I've had lots of experiences in life that other people don't have yet I find myself in the position where I need to ask for help but I sometimes don't because I'm too proud. (Pav)

J.P. Fears the possibility of having an amputation. Whilst his leg was saved from the IED blast, he was told that the daily pain and swelling he experiences might lead to an amputation.

The fears are (...) maybe, two, three years down the line, I'll have to have me [sic] leg amputated and then I'll have to go through the whole rehabilitation process again, which will be harder this time cuz I just don't have the mentality anymore. (J.P.)

He fears both the loss of the leg and the need for a second rehabilitation process when he is older.

Colin, too, is facing further physical changes. He said:

I shouldn't look too far ahead. So, I don't. Because when you've had doctors who've said, 'You will need sticks, you may become wheelchaired.' (...) you don't want to think about that. (Colin)

The bodies of J.P. and Colin demonstrate an 'unruliness' (Achter, 2010) and are unstable (Mitchell & Snyder, 2006). Participants who experience limited daily physical action and social interactions

due to their traumatic injury can experience an increase in 'distress' (Schnurr, Lunney, Sengupta, & Sprio, 2005) and 'negative health effects' (Kypraiou, et al., 2017).

It was vital to Andy to redefine himself and always be 'moving forward', even if there was a physical price to pay at some point in the future. Andy is aware that physical changes will happen in his future but, for now, it is important to him that he be the one deciding his current level of physical activity, even if he will have to '*suffer the consequences later*':

[My] two biggest fears are, em, so...physically, they've (his Consultants and Prosthetists) obviously said 'Don't do so much running. Don't go and kind of do all these things because your left leg is obviously overcompensating for your right and then one day your hip might go, your back might go, your knees, ankle, whatever...' But I think to that, I could not do any of that and I could still suffer these problems. So, I'm gonna live life to the full now and I will suffer the consequences later. So I guess, I'm not gonna change my life. I'm gonna still keep doing all these crazy things I do. But yeah, I guess the fear is that, one day, life may become a bit painful and it might be bit you know, but that's gonna be down to my doing. I can't really blame anyone for that...that's just my own...that's my physical fears. (Andy)

This concept that Andy describes of living '*life to the full*' is what Brewin et al. (2011, p. 1737) call 'living deliberately', because veterans describe life 'as being important above all else and should be lived to the full'. It is clearly important to Andy and his well-being that he remain active, despite warnings from medical practitioners. As Andy mentioned, he could follow the advice of the medical field and still have all the physical problems when he ages.

Fears for others

Others had different fears about the future, which included the state of global affairs and concern for other veterans. Considering the former military career, this type of fear seemed perfectly in tune with their former military-focussed narrations. A.D. stated, '*Fears for the future... I have sort of grand fears for the future. I'm not talking about me now. I'm talking about the West, the world, in that respect.*' A couple of participants were quite direct about the provision of veteran welfare for having served in Iraq and Afghanistan. For example, Ken stated his concerns are

specifically about the care of limbless veterans and future interventions, such as counselling (Brewer, Jeffers, Petitpas, & Van Raalte, 1994). Ken worried about physical and psychological care as well:

I do feel if someone doesn't make a conscious decision on how we're going to handle, especially injured service personnel, at certain points—five years after, ten years after—and how those...Unless there's a plan, and there's no plan, clearly there's no plan. (...) [T]hat big groups of people [injured soldiers] in twenty years' time, you could have a big group of limbless veterans killing themselves. (...) It's just making sure that all those robust systems are in place to look after us. (Ken)

Ken indicates that traumatically wounded, limbless veterans will possibly have unaddressed psychosomatic issues throughout the remainder of their lives. Unlike the acknowledgement US veterans face by burdensome 'debts of gratitude' (MacLeish, 2013) or being made to feel like a victim or hero (Wool, 2017), participants expressed concern that it was possible that British society did not seem to care:

I think a lot...my fear used to be...and I fear it's already been realised. Which I kind of...you asked me what my fear was for the future (...) soldiers would be forgotten about. To be honest, I think that's already happening anyway. In that sense. Afghanistan is old news now and so that fear's already come to realisation. (Andy)

This concern is supported by Brewin et al. (2011), wherein US veterans described 'disillusionment' about civilians' lack of appreciation (p. 1737). Andy is also concerned about ex-service members being trapped in their past war experiences and being unable to move past those experiences.

[It] is one of the reasons I've got into the motivational speaking and (...) got on with the [competitive] running. I didn't wanna be playing that old song of 'I was in the war and I've done this.' So, I think that's why some lads may become unwell in the future, become bitter about and angry about—that they've been forgotten about. (Andy)

Paul, too, shares the worry of future care and well-being of ex-service members, specifically other injured service members who will need house adaptations. Whilst the Armed Forces

Covenant aims to ensure care for the rest of veterans' lives, the ease of use and applicability is not always apparent for ex-forces.⁴⁷ Paul's recent experience with an offer to do home renovations (mentioned above), which were incomplete at the time of our interview, has pushed this issue to the forefront of his mind. Paul is worried about other veterans having a home that is inappropriate for a person with disabilities:

Resettlement—clinical recovery and stuff like that, it's [military-provided care] top notch. Resettlement is there to offset other...[issues]. And there's also things outside of that where you can get help, or require help, such as home adaptations (..) the wider MoD um, are looked at as being able to look after our servicemen/women, veterans or whatever, like, second to none. Which is absolute bullshit. (Paul)

A.D. is worried for other injured veterans and the length of time it takes to receive compensation or pensions. He understands the various issues one must deal with whilst going through a medical discharge:

I don't know how the Veterans Agency have got to their decisions. So I don't know. But I have never had an issue with the amount the awarded or the percentage of disability they decided upon. Not an issue. But the Christ! The timescales involved - just shocking! ... But it is quite - having it hang over your head - I find quite stressful. And they could really improve injured veterans' lot, really improve by, upping the time - or by shortening the timescales. (A.D.)

A.D.'s narrative illustrates what Wool (2017, p. 80) describes as the 'temporality of endurance'. This concept is where a person feels trapped 'in a difficult and undesirable present that does not seem to advance toward the future' (Wool, 2017, p. 80). This form of limbo is '*quite stressful*' for A.D., which adds anxiety to an already nerve-wracking situation.

Hopes

Several participants spoke about their hopes to continue to help others, such as designing prosthetics, teaching, or giving public lectures. Dave speaks about helping others with his

⁴⁷ www.armedforcescovenant.gov.uk

prosthetic designs, as he experiences certain limitations surrounding full participation in his children's lives. With that in mind, Dave told me about his current status with his university course:

I'm hoping I start designing legs pretty soon. (..) I hope that work I do in the future opens up more of these real-life things that form the important parts of life. (..) I'd like to be able to contribute more the everyday stuff in life rather than be limited by the technology that I'm using at that particular point in time. (Dave)

J.D. would like to spend his days doing more to help others through education:

I hope to do a bit more teaching. (J.D.)

Lee mentioned rowing across the Atlantic Ocean as well as planning future talks and trips:

I'm hoping to earn a living talking on the talking circuit. (..) I wanna organise an expedition to Patagonia, on horseback, with wounded soldiers, veterans and, perhaps, get television involved. (..) [My] hopes [sic] is that I can earn a living doing it. (Lee)

Many narratives about the future are about incorporating bodily limitations and learning to work with them to navigate the future (Gilleard & Higgs, 2018). For example, a couple of participants explained to me that they really could not plan anything long-term due to the impact of injuries on daily life. Colin told me he could only plan in six-week timeframes:

And what I've learned to do is, I work in six-week blocks, and that really works for me. (..) And I think that's how I live now. Everything is on a six-week cycle and it keeps me, it keeps the negative thoughts at bay. Because in six weeks, I'm not going to deteriorate that much I'm not going to be able to something, yeah, I might have a flare up in that time... I might have a flare up when it comes to that particular occasion, but flare-ups happen. And I'm happy with that because I know how to, to manage them. (Colin)

Colin's concern of deterioration is couched in terms of managing the future in blocks of time that are easy for him to imagine. Therefore, he can 'keep negative thoughts at bay' as long as he continues to use this particular framework of time. A.D., too, thinks of the future in a type of daily timeframe:

I am much more 'day at a time' than I was. And I think that's more, as a result of the whole rather than any particular aspect of the injury, the whole experience. (A.D.)

Pav, who knows his spinal cord injury will continually limit his possible daily activities, said that he would like to find something travel-related:

I hope that I find that next chapter to fill it, but, eventually, give me that thing in life that goes in some way to replacing what I had and having enjoyment for whatever that may be. (Pav)

Pav further stated that finding acceptance about his situation and his painful bodily limitations, is his hope. Li and Moore (1998) argue this acceptance can be difficult for people who have acquired their disability, especially if they experience the comorbidity of chronic pain. As Pav stated, he needs to accept the past:

Acceptance. Need to carry on accepting that it's gone and to concentrate on looking forward rather than behind. (Pav)

J.P.'s hopes are tied into the unknown length of time for the functional capabilities of his damaged leg:

I hope my leg doesn't deteriorate as fast as I think it's gonna and I can carry on the way I am for a good ten years yet...(J.P.)

Conclusion

This final empirical chapter investigated participants' narratives of their current daily activities. The overarching themes of continuity through serving and having a purpose was evident. Participants told stories about work. They also spoke about volunteering through public speaking, giving time to military charities, or fundraising. Education—both attending university and teaching others—were mentioned. The importance of goal setting was addressed by a couple participants. Lastly, narratives about the future were examined. These narrative themes uncovered concerns

for future—specifically participants’ bodies as they age as well as financial worries. Several participants spoke about their concern for other veterans, particularly for their future psychological and physical well-being. When speaking of hope, participants narrated continuing on with their current activities, planning for the future, and acceptance.

Chapter 9: Conclusion

Introduction

This research investigated the life stories of twelve service members who experienced a life-altering traumatic physical injury that ended their military career. Their injuries, incurred during deployment to a war zone or whilst serving in the United Kingdom, testify to the precariousness of a physical body and having a career predicated upon physical capabilities. Many readers of this research will have no direct personal experience of military service, deployments to war zones, or severe career-ending injury and the resulting dilemmas that may ensue surrounding identity and embodiment. Additionally, it can be difficult to even imagine the loss of a career that is so focussed upon one's personal community, or team, and which mapped itself out onto the relationships military members developed during their service. These all-encompassing issues of identity, embodiment, careers, and relationships are thus investigated here through the process of narrative inquiry with the collection of post-injury stories.

Narrative inquiry enables further in-depth awareness and comprehension of how much lives change when the body is drastically altered, maimed, or otherwise chronically physically impacted (Frank, 1995). The narrative approach is also able to explore and highlight the value participants placed upon their military rehabilitation, specifically their shared sense of community and mutual understanding of traumatic injury. The importance of storytelling as a research method can increase the trustworthiness of narrative experiences dealing with disability for listeners (Berghs, Atkin, Graham, & Thomas, 2017) and can be cathartic for the storyteller (Vassallo, 2008). Storytelling can also aid in bridging cultural divides between military veterans and civilians (Mamon,

McDonald, Lambert, & Cameron, 2017). These stories can be helpful to fellow veterans because 'their [veterans'] stories make a difference, achieve something, help someone' else (Carless and Douglas, 2017, p. 381), as in the work of Schrader, a former US service member (2019, p. 69), where 'veterans were excited to be helping a fellow veteran with a PhD project which they saw as strengthening the community for veterans'.

My research aim was to use stories to uncover rich, detailed narratives of life following a military-related traumatic injury resulting in dismissal from the UK Armed Forces. This material made an effort to fill the dearth of knowledge that exists about post-military lives and the significant event of military discharge following a traumatic bodily injury. The richness of my participants' stories illuminated trials, tribulations, as well as the resilience they had during recovery.

Key findings

This current research contributes to an emerging body of qualitative work focussed upon wounded, injured, and sick (WIS), veterans in the United Kingdom (Caddick, McGill, Greaves, & Kiernan, 2018; Brittain & Green, 2012; Green, 2016) and American veterans (MacLeish, 2013; Wool, 2015; Messinger, 2010; Finley, 2011). The data presented within this thesis increases empirical knowledge about ex-service members' personal psycho-social and corporeal experiences, providing critical insights of an extensive, painful, physical recovery and the various institutional structures and processes negotiated whilst doing so. This thesis further contributes to knowledge for critical military studies by providing empirical evidence of the positive effects of communal military rehabilitation through routines, empathy, camaraderie, and humour, which aided the participants' well-being. Moreover, this research builds upon disability studies as it contributes to narrations of the daily subjective, embodied experiences of people who 'acquire', or obtain, an impairment or disability as it examines the dual changes injured participants faced: a *reintegration* into the civilian world as well as a *reconciliation* of a new way of (physically) being.

Unlike other research investigating post-military life through a new career choice (e.g., private military contracting) (Higate, 2013), exiting the military for a sometimes unknown or unknowable future (Walker, 2016), or through planned retirement (Williams, Allen-Collinson, Hockey, & Evans, 2018), this current data focuses upon the desire to, or the necessity of, finding a new career with (sometimes extreme) bodily limitations due to injury. This work has some resonance with Caddick, Godier and Fossey's (2017) research covering wider 'early service leavers', which attempts to understand the difficulties transitioning out of the military and possible vulnerabilities returning to the civilian world, including finding employment, loss of friends, and support. The participants in this study also struggled with these issues but did have resettlement services extended to them during recovery and after discharge, unlike some early service leavers.

Prior to injury, the participants spoke about days filled with physical activities—both in the United Kingdom and whilst deployed. Maintaining good physical shape is important in the military and several participants mentioned how they were in peak physical fitness when they were injured. For example, Mark spoke how that impacted his approach to rehabilitation as a *physical challenge* to overcome and to set goals (Oliver, 1996; Achter, 2010).

Experiencing a traumatic injury after having a highly trained, skilled physique is a major life disruption (Bury, 1982). As mentioned earlier in this thesis, we can understand how an injury would impact athletes (Rembis, 2013), dancers (Rivera, Alexander, Nehrenz, & Fields, 2012), and others whose bodily use is tied to their ability to earn a living. Participants' injuries not only affected their bodies and relationships, but also ended their military careers. There was no replacement career for many participants or, if so, it would be outside the scope of their previous military work experience. Participants learned to be creative by using the very thing that ended their military career to begin a new career—speaking publicly about the injury and its aftermath. However, learning to negotiate a different body takes time, resilience, and persistence.

Interviews with ex-service personnel had a common narrative thread of embodied, habitual resilience that is partly instilled in basic training through controlled, repetitive, collective movements of recruits' bodies, creating a method of coping with 'physical hardship and hazard' (Hockey, 2002, p. 155). This technique is then built up through the ensuing military routines and experiences over time, and further applicable to the rehabilitation process (Caddick, Smith, & Phoenix, 2015). The resilience articulated within participant narratives was extremely significant and it does raise the possibility that military training and military community can engender forms of resilience that remain (or re-surface) after a service member is inflicted with extreme, catastrophic bodily wounds and the resulting physical and social complications. This finding supports previous qualitative work with amputees done by Caddick et al. (2018), especially with regards to the concept of struggling against decline as one ages with limb loss. The evidence in this thesis suggest that the delineation put forth by Caddick et al. of 'adapting to struggle' (positivity, resolve, and resilience) versus 'struggling to adapt' (loss of independence, frustration, increased bodily issues) is quite apt for participants who have experienced traumatic injuries (2018, pp. 27-28).

The communal rehabilitation provided by the military had a positive impact on almost all participants (the exception was Jon, due to his being placed in the Head Wound Ward whilst not having a head injury). Whilst in rehabilitation, the participants described their experiences of military friendship and continuity. The paths of rehabilitation and recovery were not always well-defined or easy for my participants. Rehabilitation within the military setting at Headley Court was spoken of in a positive fashion by the majority. This positivity reflected a continuation of being surrounded by people who would understand what the others experienced, usually without having to discuss the trauma, wounds, or physical ailments that occurred. The idea of a hierarchy of wounds was mentioned by those who had spent time in rehabilitation (see also MacLeish, 2016; Deal, 2003; Berghs, 2007; Onishi, 1999). This often framed the participants' narratives as placing themselves 'higher up' the perceived hierarchy allowed them to view their own injury in a more

positive light (cf Carless & Douglas, 2017). In particular, this narration type supports what is called the 'disability paradox', wherein a person with disabilities has a more positive perception of their quality of life compared to an observer, who would think the person with disabilities has a poor daily life (Schwartz, Andresen, Nosek, & Krahn, 2007). As mentioned previously, positivity helps with coping and dealing with obstacles, be they mental or physical (Caddick, Smith, & Phoenix, 2015; Wilson, et al., 2011).

These rehabilitative spaces also allowed new friendships to form. In particular, by being with and around other military service members, my participants spoke of their ability to use humour as a positive part of their rehabilitation (see also MacLeish (2013), Wool (2015), and Caddick (2018)). Whilst not officially implemented by the institution, for those who were within Headley Court, humour and related 'antics' were permitted because they are an important part of what defines relationships within the military (Hinojosa, 2010; Dickson, Allan, & O'carroll, 2008). As MacLeish's (2013) ethnographic work indicated, service members can use humour and other antics to 'move past' their shared and unspeakable experiences.

Most participants found varying levels of difficulty trying to exercise agency within various 'systems' after their military exit (e.g., military rehabilitation, military charities or 'third sector', and National Health Service systems). Deciding when and how to discontinue addictive pain medications, or individually finding appropriately trained prosthetists, were two narrated forms of attempts to reclaim agency. By making these decisions and acting upon them, participants become their own 'knowing subject who is an advocate for his or her own experience and expertise on the capability of their body' (Messinger, 2010, p. 293).

My data indicates that a departure from a military career due to medical discharge proved to be a somewhat challenging transition for several participants. 'Institutionalisation' (Coser, 1974; Segal, 1986) appears to have carried over from—and past—their medical discharges, thus creating a 'post' military life versus 'ex' military life because participants continue to identify so strongly to

their past. This was in part because the very decision to leave the military was ultimately not one of their making, unlike service leavers who exit the military due to various other circumstances, such as retirement, marriage, beginning a family, or embarking on a new career (Walker, 2016).

The transition narratives of the participants can be categorised in terms of three broad types: two dominant themes, planned and shocking, and a minor subtheme of 'betwixt and between'. The theme of a planned transition reflects the ability of four of my participants being able to negotiate their exits, as they had a relatively fluid transition after medical discharge and military exit due to rehabilitation and resettlement training. The narratives indicated acceptance and preparedness of an impending medical discharge:

[I did] a 'gardening leave' so that I could get back home and sort everything out for work and things. (...) I did all the resettlement through the job-seeking things, writing CVs and all that. (J.D.)

It was all there I just decided I was doing my own thing. (Jon)

Lee returned to duty post-injury and stated that his chain of command:

[...] they humoured me. Looking back on it, they, they allowed me to come to the conclusion I could no longer really strictly do it. (Lee)

Dave returned to university whilst working in a Personnel Recovery Unit until his discharge:

I had 6 months of doing my master's whilst employed by the military and the, the final 6 months as a veteran. So, I got discharged half-way through my Master's, which, I think, was probably ideal. (Dave)

These participants—J.D., Jon, Lee, and Dave—narrated a relatively smooth transition discharge and military exit. Other participants, however, did not express this fluidity.

In the 'shocking' transition out of the military, service members lose the shared experiences, meanings, and friendships (Hale, 2008; Herman & Yarwood, 2014), certain social resources and military structure (Cooper, et al., 2017; Albertson, 2019; Ahern, et al., 2015), and a sense of identity (Cooper, Caddick, Godier, Cooper, & Fossey, 2016; Williams, Allen-Collinson,

Hockey, & Evans, 2018; Binks & Cambridge, 2018). These participants were overwhelmed at times, echoing MacLeish's description of how 'the system' decides 'how he [the service member] is to proceed and what is to become of him' (2013, p. 110). This feeling that it was not a participant's 'choice' was quite common:

'It was all taken away. [...] to suddenly find the organisation you've given 26 years of your life to, particularly your healthy years, suddenly doesn't want you anymore.' (Colin)

'[T]hat had all been taken away from me and I was lost.' (Mark)

These were narrations of loss, bereavement, and grief (Schlossberg et al., 1995; Giddens, 2005; Albertson, 2019):

I look at the loss of what I had, really, um, almost like a bereavement. (Pav)

The day you leave, you might as well never have existed, outside of your mates.
(A.D.)

Participants who expressed a shocking transition expressed strong feelings of a lack of control over the process of military exit after their medical discharge.

During the transition process, participants explained that they attempted to find new ways of developing agency within systems of care and new ways of governing their body. All of the participants used the NHS for various therapies, follow-up surgeries, and continued provision of prosthetics. Several participants reported issues with their local prosthetics clinic not having appropriate familiarity with the types of prostheses the men used. Further, the participants reported that they needed to control their pain medications by stopping or lowering the daily amount of physical pain medications. As Mark stated, *'My brain would just fry really quickly'* whilst taking his pain medicines. J.P. remarked, *'I had a little bit of an addiction'*, and Paul declared that he did not want to be a *'fucking zombie'* because of prescription drugs. The felt need for the men to be in control of their bodies was paramount. Many of the participants stopped taking daily doses of painkillers and learned to live with various levels of pain.

Continuing to view—and speak about—oneself as able and independent was a prevalent narrative; many participants resisted being labelled as disabled. This resistance is found in other qualitative work focussed on war-wounded bodies (Berghs, 2008; Vassallo, 2008; Achter, 2010; Aciksoz, 2012). This perception was not without narrative tensions, however, as Andy's quote demonstrates:

I knew in my head from Day One I probably wouldn't be able to stay in the Marines. [...] And it was when I heard someone say, "You're not fit enough" for a second, for split second, I felt like saying, "Actually, you know, I take that back." You know, "I'll prove to ya that I am." (Andy)

This tension or strain was, at times, what I would call an undercurrent during a few interviews. For example, whilst Mark spoke extensively of how amazing his life has been since his injury there were times in the interview when he acknowledged the difficulties of living with—and on—prosthetics each day (such as walking on uneven surfaces due to constant vigilance for people and things that could make him fall). Mark stated, *'I can't ever [...] go out shopping and be completely relaxed like I used to. I'm always thinking about my legs.'*

Whilst the stories told often suggested that the majority of the participants were physically autonomous, their narratives also revealed the conditionality and ambiguity of that autonomy. I refer to this as 'conditional corporeality' because the participants' bodies function but with uncertainty and limitations. These limitations can be due to insurmountable pain or to the fact that the body has been surgically repaired in such a fashion where it cannot perform in the same way (due to scar tissue or the thinness of the skin graft.) Another example of limitations set by the body is a form of what I term as 'body rationing'. This strategic tactic was when participants spoke of the necessity of choosing when and for how long they could use their body. This regulated, measured approach to bodily use was mentioned by several: Pav's attitude for practicing for the Invictus Games with his spinal cord injury stated that *'instead of smashing into it'*, he would *'build it up a bit more slowly'*. Pav further implied that if his body has problems, *'there is nobody there to fix me*

now’, indicating the military is no longer his provider for high-level, specialist healthcare. A.D., with a traumatic brain injury, spoke about sleeping for almost two days prior to volunteering as a Court Magistrate so he avoids having ‘*a seizure in court*’. J.P., who has ongoing leg problems, said quite succinctly, ‘*I don’t want to burn it out*’. The corporeal reality for participants is that they must evaluate their body’s capabilities, their responsibilities, and the need for more recuperation time after being physically active. Additionally, the reliance upon technology impacts the ability to be physically independent, or, as Serlin (2015) states makes the user ‘technologically dependent on devices and networks that provide the illusion of autonomy’ (p. 45). As multiple participants indicated, prosthetic legs with micro processing knees need to be charged to function, which impacts how they can plan their daily activities.

In an attempt to better conceptualise and explain conditional corporeality, I have devised my own terminology to define varying levels of independence and physical autonomy that my participants narrated (discussed in chapter seven). I suggest three typologies in order to help clarify the bodily expectations, limitations, and endurance needed for daily functioning were ‘Anchored’, ‘Adapted’, and ‘Ascending’. Those who are ‘anchored’ had the least physical independence and highest, consistent pain levels, which impacted the participant psycho-socially. Participants in the ‘anchored’ category narrated limited amounts of physical functioning each day, wherein pain oftentimes incapacitated their ability to exert themselves. Those who had ‘adapted’ are able to be independent (but must ‘ration’ body use) and experienced pain but they were able to withstand it. Those who are ‘ascending’ were highly physical and involved in competitive sport, such as the Invictus Games. The suggested conceptual categories are not static for participants, as they could move into a different type of category due to a health event (e.g., blisters, surgery, or infection).

All participants expressed a common theme of struggling to settle in civilian society. Several mentioned that ‘civilian’ issues are not the same as what they perceived as ‘real’ issues.

'No one's issues in the civilian world life seem as big as they make out once you've been surrounded by friends with no legs and no arms and stuff' (Andy)

'I haven't got time for bullshit or the menial crap in life.' (Paul)

This experience is nonetheless accompanied by the loss of a recognized and respected past, a loss of 'knowing' in general—of who one is and the purpose one has. My participants were thus often quite clear in their desire to set goals, both personally and physically, in an effort to continue to be the person they felt they had been prior to injury. Furthermore, many of the things my participants choose to do with their time either through paid employment or volunteering reflect their desire to continue to serve in some capacity and help others.

I run a support group. (J.D.)

I try to do one thing a year for charity. (Paul)

I've got involved in telling my story to younger people, part of teaching them resilience. (Ken)

When asked about their future, in terms of hopes or fears, participants spoke of both themselves and the world around them. Three mentioned limited views into the future:

Everything is on a six-week cycle and it keeps me, it keeps the negative thoughts at bay. (Colin)

I am much more 'day at a time' than I was. (A.D.)

I'm in that holding pattern at the moment. I'm like in a tunnel. (Ken)

These examples are reflective of an inability to have long-term visions for some participants' futures. Several participants experience a temporality of discrete short-term timeframes (a 'day at a time' or 'six-week cycle') and continuity (a 'holding pattern'). A few participants narrated the capability of continuing their current activities of employment or volunteering, such as J.D. continuing to teach or Lee's organizing an expedition trip. Others, like Dave, spoke of his aim to finish his university course to design and provide more useful prosthetic designs. Many participants addressed financial concerns about impending costs, especially for the

prosthetics they will need for decades. The future of some participants carries with it another physical failure, such as J.P., who mentioned dealing with a worsening leg for some time: *'I hope my leg doesn't deteriorate as fast as I think it's gonna.'* J.P.'s future holds the possibility of amputating his leg and he narrated his struggles with that knowledge. One participant in particular, Pav, acknowledged an emotional aspect of injury—acceptance.

Researching military lives

Turning to a reflection upon researching military lives, I wanted to reiterate the issues mentioned in chapter four surrounding access to this community of ex-forces. Much of my time was spent establishing trust amongst the 'gatekeepers' in both military charities as well as the active duty community. Waiting for the 'gatekeepers' to grant me entrance to the military community took many months of communication (emails, phone calls, messaging through websites) and arranging in-person visits to speak with them face-to-face. Moreover, these ventures did not always lead to introducing me to possible participants despite the amount of time and effort it took to achieve a 'gatekeeper's' trust. Several high-level 'gatekeepers' specifically mentioned protecting 'their' beneficiaries, which implied a level of protectionism and reiterated my 'outsider' status at the beginning of the research. In each of these instances, the 'gatekeeper' prevented access to any veterans. One 'gatekeeper', for example, wrote to me that there was 'a risk of exposing *our veterans* to too many outside interviews' (emphasis added). Unfortunately, this paternalistic behaviour meant that possible participants were never approached, even though the veterans were capable of making the decision to participate (or not) in my study. Therefore, I could not speak with the people whose stories I was trying to collect and highlight for a wider audience.

Gaining access to this particular community is not a new issue (Cafario, 1998; Baker, Basham, Bulmer, Gray, & Hyde, 2016; Walker, 2016; Schrader, 2019). However, I would encourage future researchers not to overlook this potential difficulty in the fieldwork phase. I suggest building

in additional time at the beginning of the research project for ‘relationship building’ with all parties that have the power to determine the access, or otherwise, that the researcher will eventually have to possible participants. This ‘relationship building’ with military communities and their ‘gatekeepers’ cannot be underestimated. The military is a ‘close-knit community and there is a need to build relationships with the “insiders”’ (Baker, Basham, Bulmer, Gray, & Hyde, 2016, p. 7). Whilst I had been properly trained for research, had educational qualifications, and military-related experiences, the fact is those pieces merely opened the door for me. It remained my responsibility to pursue the ‘gatekeepers’, ‘insiders’, and participants. My experience with approaching ‘gatekeepers’ and ‘insiders’, as well as recruiting participants, required me to be flexible and adaptable—with time (allowing days or weeks to pass before having a visiting date set in the diary), with various communicative approaches to national, local and individual organisations and networks, and with my own readiness (rearranging a schedule to be available within a day or two to meet for interviews).

Whilst access was extremely complicated and time-consuming, it is was ultimately well worth it to have the qualitative data collected herein. Further, qualitative, narrative research is extremely valuable and thus more longitudinal narrative inquiry should be undertaken, especially with a cohort such as was investigated in this thesis. This thesis reiterates the necessity of adding to empirical knowledge by examining not only a specific moment in time (e.g., the injury, rehabilitation) for disabled ex-forces, but to investigate life stories temporally. Participants’ stories began with the injury and continued through their vision and realities of their future. Through narrative inquiry, my research demonstrates the significance of ‘seeing’ into the lives of veterans who, whilst injured and subsequently discharged, exemplified a deeply engrained resilience but also the banality, frustrations, and challenges of life with an acquired disability. Furthermore, this narrative data identifies ways ex-service personnel make meaning of their post-injury life through continuities in their ‘calling’ by serving, such as volunteering or teaching.

Interestingly, none of the participants voiced criticism of the military or their time serving despite their severe career-ending injuries. Whilst they referred to the process and timeline of receiving pension benefits as ‘gobsmacking’ or, in another’s case, criticising the MoD’s approach to their housing adaptation as incredibly inconvenient. Loyalty could be the reason for this behaviour. This could be, as Jolly states, ‘Caught young enough, the forces can mould the behaviour of their brightest recruits, use their skills and intelligence, and can instil in them a fierce sense of loyalty’ (1996, p.21). Levinson (2105) asserts:

The military’s core values of loyalty, obedience, and duty form a very effective buffer against dissent, discouraging people with military affiliations from expressing disaffection or doubt. (..) Those intense bonds, which the military relies on in combat, continue after people get out of uniform; even those who reject the military’s mission often feel proud of their service and affiliation (p. 13-14).

Therefore, if one criticises the armed forces, it can be viewed as being disloyal. Further, if we view the participants as belonging to the ‘greedy’ military institution, they may hold a ‘devotion to [the] institution’ (Moelker & van der Kloet, 2006, p. 209). It is also possible that, due to my being an ‘outsider’, the participants may not have wanted to criticise the organisation to which they belonged. Perhaps voicing dissent or critiquing the deployments would, in some way, discredit the participants or make them feel like victims.

Lastly, although this research was not oriented specifically towards the production of policy recommendations, it is possible for qualitative research to positively impact policymaking, its development or evaluation (Berghs, Atkin, Graham, & Thomas, 2017; Caddick & Smith, 2018). Whether it is focussed upon healthcare, education, or employment, investigating daily life can be beneficial in the effort for policymakers, practitioners, and charity organisations to make decisions. Recent studies and reports (e.g., (Heal, Crouch, Halkiopoulou, Fussey, & Kirkman, 2019; Søndergaard, et al., 2016; Binks & Cambridge, 2018; Ashcroft, 2014)) concern themselves with the investigation of military-to-civilian transitions, yet few focus explicitly upon military exit due to medical discharge and using the qualitative research needed therein. This current research can

inform healthcare workers and other practitioners about both the positive and negative experiences of limb loss and spinal cord injuries. This study can significantly contribute to the encounters between practitioners and the injured.

Future research

The lives of my participants, in one moment in time, changed their corporeal abilities and life focus. This type of event occurs in civilian lives as well—through illness or accidents. My suggestions for future research are based upon my research into military personnel rehabilitation experiences but encompass civilian lives as well.⁴⁸

‘Rehab Better’: Competitive military rehabilitation

The concept of being able to ‘Rehab better’, as one participant revealed, is a novel one and remains an unexplored avenue of military rehabilitation. As was mentioned in chapter five, it is common for the Armed Forces to have an inter-services rivalry (Hinojosa, 2010). Considering that my participants spoke favourably of the rehabilitation experience, it would be interesting to investigate if the ‘rehab better’ concept has existed for other wounded service members in the various Armed Services. Future research exploring how military rehabilitation is institutionally framed as well as individually experienced around the concept of ‘rivalry’ or competition could be illuminating, especially if viewed favourably for the military-to-civilian transition period (Goff, 2012; Chockalingham, Thomas, & Duval, 2012; Caddick & Smith, 2018). We can see examples of this type of rivalry in the Invictus Games and USA ‘Wounded Warrior’ Games. However, approaching rehabilitation research focussed upon competitiveness has potential negative psychosocial

⁴⁸ Importantly, I must note that this research prompted me to begin another small qualitative research project within NHS England. I interviewed civilians who have spinal cord injuries or amputations. I will be in the process of transcribing and writing up the findings from that study once I am done with this thesis.

implications, such as framing health and rehabilitation as a ‘battle’ or ‘competition’ with winners and losers. Further, competition and rivalry could create other possible issues, such as exclusion or further injury. Therefore, future qualitative researchers investigating this topic would need to be careful about developing the appropriate framework for understanding this concept and its effects on wounded, injured, and sick service members.

‘Rehab Together’: Collective, communal rehabilitation

Unlike the *competitive* rehabilitation mentioned above, a second type of rehabilitation—a *collective* rehabilitation—could be contemplated for further qualitative research. Considering the narratives within my research population, exploration of collective (or communal) rehabilitation for civilians after being injured and through recovery is worth pursuing. Participants’ accounts about their positive experiences of collective rehabilitation could lead to a more nuanced exploration of the perceived benefits. Shared norms and experiences of seeing, speaking, and being with people who are ‘like me’ immediately following a traumatic injury could provide psycho-social benefits. This type of communal rehabilitation, a ‘Rehab together’ approach, could have progressive practical and policy ramifications. Moreover, it could be illuminating to see if a group setting is beneficial for the patients. For example, investigating self-esteem for traumatically injured people who share hospital and rehabilitation spaces with other people with similar injuries for long periods of time. Too, it would be worthwhile exploring if the act of narrating their lives and injury experiences might influence patients’ well-being and recovery.

Concluding thoughts

The data gathered during my fieldwork revealed additional areas for further exploration that were beyond the scope of this thesis. I intend to look into these areas of expansion and my

future goals include investigating narratives of personal and intimate relationships, and experiences of the care team the participants had (or did not have) once discharged. There are inevitably certain ‘missing voices’ in this particular thesis—including the carers of WIS and injured female veterans. Whilst it was not intentional for all the participants in this study to be men, the two women that were contacted were ultimately not able to participate. And while the experiences of carers were not the focus of this thesis, it would be possible in the future to contact my participants to enquire if their carers or families would like to address the experiences they had once their service member returned home after rehabilitation. Additionally, I would be interested in pursuing a further longitudinal dimension to the study by following and interviewing the current participants over time, comparing their health and well-being as they age to their narrations found within this thesis.

One of the most important findings of this research is the participants’ narrations of resilience about their injuries and experiences. The overarching themes of adapting to a different body and different life, trying to find agency and control, and developing a new form of physical autonomy were significant and illuminating. I offered new conceptual categories of narrative independence: ‘anchored’, ‘adapted’, and ‘ascending’. Additionally, I presented two novel concepts, ‘conditional corporeality’ and ‘body rationing’. This research is unique due to the fact that it has a long temporal dimension—investigating life stories from when the participants served in the armed forces, through injury and rehabilitation, to their projection of what their lives will look like over the immediate and long-term future. Shared stories about time in service aided in the analysis of participant narratives of struggles, persistence, and resolve whilst they began a life they had hitherto not imagined. The complex dynamics of the stories brought to light here significantly contribute to the empirical knowledge of the ways in which post-military lives are lived, experienced, and narrated after a traumatic injury resulting in a medical discharge. Taken together, these narratives reveal how traumatically injured ex-service personnel endeavour to transform their embodied challenges into lives well lived.

Appendix A: Interview Schedule

Interview Questionnaire, Version 1.0

Basic Demographics

1. Name
2. Age
3. When did you serve in the military?
 - a. What rank did you achieve?
 - b. Were you deployed?
 - c. If yes, how many times and to where?
4. Are you married or in a relationship?
 - a. If yes, how long?
5. Do you have children or stepchildren?
 - a. If yes, what are their ages?
 - b. Do they live with you?
6. How long were you in hospital following your injury?
7. How many doctors or therapists did you see for your injury?
 - a. Do you still see them?

Open-ended Questions

8. Please tell me about what a typical day was like for you before the injury.
9. And what are your days like now?
10. How you were injured/what happened?
 - a. What type of injury/loss did you experience?
11. When were you injured?
 - a. Are there multiple injuries present?
12. Some of the materials I've read about veterans deal a lot with bodily senses and remembering. Do you find any sights, smells, or sounds return you to the moment?
13. What surgery or surgeries you have undergone?
 - a. How many have you had?
 - b. Will you have any more?
 - c. Have you had any problems with anything after surgery, such as complications, which brought on the need for another surgery?
14. Have you had any physical issues after surgery or during the recovery process?
 - a. Have you experienced fatigue, weight loss/gain, sleep loss, or other issues?
15. Can you tell me what resettlement was like for you when you were leaving the military?

16. What opportunities have you had to connect or befriend others at the hospital, during rehabilitation or at the recovery centres?
 - a. Are there others who have the same injury as you?
 - b. If yes, how far along in their recovery are they (in comparison to you)?
 - c. Do you use the Internet to interact with others who are injured?
17. What activities do you do or have you tried for fun or interest (such as photography, drawing, swimming, biking, cooking, or volunteering)?
18. How would you describe your relationships/friendships?
 - a. Could you give me examples of some you find positive?
 - b. And do you feel some are not positive or supportive of you?
19. Are you currently living at home?
 - a. If yes,
 - i. Where is “home”?
 - ii. Who lives with you at home?
 - iii. Do you have relatives nearby?
 - iv. Who, of these people, are able to help care for your needs?
 - b. If no, where do you live?
 - i. What do you expect that to be like? / What is that like?
20. Have you completed all plans for rehabilitation?
 - a. If no, are you currently receiving physical or occupational therapy?
 - b. If either yes or no, have any previous bodily regimes, e.g. Basic Training exercises, helped you during rehabilitation and recovery?
 - i. If yes, could you describe them to me?
21. Do you have or need a prosthetic?
 - a. If yes, can you tell me the perks or challenges of having a prosthetic?
 - b. Do you recall how long did you have to wait to receive your prosthetic?
 - c. Can you explain what the experience was like to get your prosthetic (what happened when you were at the doctor/physiotherapist’s office)?
 - d. Have you needed more than one prosthetic since your loss?
 - e. Could you tell me what forms of rehabilitation or strength training you experienced for your remaining limb(s)?
 - i. Can you describe how it felt?
 - f. Do you experience any residual or phantom pain?
 - i. If yes, what things do you do to try to make it feel better or go away?
 - ii. How long does that work (i.e., how long until the pain returns)?
22. Could you share with me/describe your thoughts surrounding any pain you have experienced?
 - a. Do you find “pain” to be easily describable to the medical staff?
 - b. How often do you experience pain? (Always, a few times a day, etc.)
 - c. What types of options do you have to alleviate/stop any pain you have?
 - i. Are there medicines, exercises or stretching, massage?
23. Could you tell me about how you approached your days in the hospital setting? Did you have a routine that you had to follow regardless of how you are “feeling”? (E.g. if you are tired, must you still go to rehab?)
 - a. And is this the same at home? (Do you have things you must do, such as exercises, everyday, no matter if you are tired, in pain, etc.?)

24. What are some of the techniques or therapies you have been shown in learning how to “use” your body?
 - a. How are these techniques you have learned giving you independence as you go about your days? Or are they not? (E.g., do you struggle with moving or getting around all on your own?)
 - b. If foot or leg loss or a spinal cord injury, do you have a wheelchair, walker, cane, or crutches for mobility?
 - c. If arm or hand loss, what forms of rehabilitation are you learning/did you learn that are specific to your needs?
 - d. If vision loss, how have you learned to use your other senses?
 - e. If hearing loss, do you have a hearing aid/device or are you learning British Sign Language?
 - f. If burned, did you have a skin graft? Was it successful? Have you needed corrective surgery to gain use of the area?
25. Did you receive all of your rehabilitation in the military or was it a combination of military and NHS?
 - a. How would you describe the rehabilitation processes? (E.g., were they helpful, difficult, painful, overwhelming?)
 - b. (If needing a prompt) What types of rehabilitation did you have and can you walk me through them?
 - c. If you had both military and NHS rehabilitation, did you notice any differences between them?
26. What are some of the things you feel you have learned about your body?
27. How do you feel other people behave towards you? (This can be family, friends, or strangers.)
28. What do you envision your days to be like over the next few months? And year(s)?
29. Are you currently employed or looking for employment?
 - a. If employed, what is your job?
 - i. How long have you been doing that job?
30. What hopes or fears do you have about your future?
31. Are there any other things you would like to share with me that you feel we haven’t covered or talked about today?

Final Question:

32. Sometime in the future, would you be willing to share how things are going for you?

Appendix B: Participant Invitation Letter

School of Social, Historical and Literary Studies
Milldam, Burnaby Road, Portsmouth, PO1 3AS

Contact information

Allison Roberts (researcher)

Email: Allison.roberts@port.ac.uk

Telephone number: +44 (0) 759 7422908

023 9284 6269 (department secretary)

Dr Kevin McSorley (researcher's supervisor)

Email: kevin.mcsorley@port.ac.uk

Telephone number: 023 9284 2212



Study Title: Life after Traumatic Injury: A Qualitative study of the Embodiment and Identity of UK ex-Service Personnel

REC Ref No: 15/16:25

Dear Potential Participant

I would like to invite you to participate in a research study about traumatic physical injury and life experiences. I am currently a PhD student at the University of Portsmouth, who has studied military issues for many years. My project is about gathering the life stories of ex-service personnel who have had a traumatic physical injury, such as limb loss, loss of hearing or eyesight, burns, or spinal cord injuries.

This invitation letter has been prepared so that you can decide if you'd like to contact me to participate in the research. It is your choice to participate. If you decide at a later point in time you no longer want to participate, you may simply let me know you want to withdraw. Anyone who is forwarding this to you has not provided me with your name, address or personal details. If you are currently receiving services from them, your decision will not have any consequences (positive or negative) to those services.

An Information Sheet and Consent Form have also been prepared for my project. If you are interested in participating or have questions about the project, you may contact me at Allison.roberts@port.ac.uk.

Again, participation is always voluntary and, if you decide to participate, you may change your mind and withdraw at any point by simply letting me know.

Thank you for your time and consideration.

Sincerely

L. Allison Roberts

PhD Postgraduate researcher

School of Social, Historical and Literary Studies

University of Portsmouth, Portsmouth, PO1 3AS, UK

Date: 17 Feb 2016

Version No. 1.0

Appendix C: Participant information sheet

REC Ref No: 15/16:25

Version 1.0

9 March 2016

School of Social, Historical and Literary Studies
Milldam, Burnaby Road, Portsmouth, PO1 3AS

Contact information

Allison Roberts (researcher)

Email: Allison.roberts@port.ac.uk

Telephone number: +44 (0) 759 7422908

023 9284 6269 (department secretary)

Dr Kevin McSorley (researcher's supervisor)

Email: kevin.mcsorley@port.ac.uk

Telephone number: 023 9284 2212



Study title

Life after Traumatic Injury: A Qualitative study of the Embodiment and Identity of UK ex-Service Personnel

Invitation to take part

You are invited to participate in the research project about life stories following a traumatic injury.

What is the purpose of the research?

The purpose of this research is using narrative inquiry (life stories) to gain understanding about the injury, rehabilitation, recovery and onward. The findings of this research will inform many communities, such as carers, rehabilitation specialists, medical personnel, academics and other researchers. This type of research would be useful both to practitioners involved in rehabilitation and care, as well as to those experiencing injury.

Who is doing this research?

The researcher is L. Allison Roberts, a PhD student at the University of Portsmouth, UK.

Why have I been invited to take part?

You are self-identifying as someone who has experienced a wound, such as the loss of hearing or sight, limb loss, burns, or spinal cord injury, due to a traumatic injury.

Do I have to take part?

No, you do not have to take part.

What will I be asked to do?

You will be asked to share your story of what life has been like following your injury. This will be in the form of an interview between you and the researcher.

What is the device or procedure that is being tested?

None

What are the benefits of taking part?

Benefits are that you will know your stories and experiences are reaching and informing a diverse audience, including multiple user communities within academia, practitioners, and policy-makers. Also, sharing your point-of-view may enable your stories to assist fellow veterans or service personnel who face injury and loss, as well as their carers and families.

What are the possible disadvantages and risks of taking part?

Risk to you includes the possibility that discussion of traumatic injury and surrounding issues may cause you psychological distress. I will be respectful of your privacy and feelings during the interviews in regards to your comfort level and any desire expressed to answer/skip questions. You will be free to skip questions or stop the interview at any time if you no longer wish to discuss the issue.

Can I withdraw from the research and what will happen if I don't want to carry on?

You are free to withdraw from the research at any time, until the researcher's thesis is completed. If you do not wish to continue, there are no ramifications; you would just inform the researcher that you no longer want to take part in the research.

Are there any expenses and payments, which I will get?

No, there are no payments.

Whom do I contact if I have any questions or a complaint?

If you have questions or a complaint, you may contact the researcher. Or, if you cannot resolve the complaint, then you may contact the researcher's supervisor, Dr McSorley. The next step is contacting the Head of Department, Mr Fergus Carr (fergus.carr@port.ac.uk) and if still not resolved, the University Complaints Officer, Samantha Hill (samantha.hill@port.ac.uk).

What happens if I suffer any harm?

You are free to stop the interview if you are feeling distressed.

Will my taking part and my records be kept confidential?

Yes, all of your information will be kept confidential and is protected through the Data Protection Act of 1998. Confidentiality will be maintained through every avenue available (encryption, anonymising data, locked storage within locked rooms, password-protected computers and documents) unless otherwise requested.
Anonymity is optional for this research. If you change your mind, you will need to contact the researcher indicating your preference prior to her publication in 2018. Participants can choose to be fully identified, partially identified, remain anonymous (allowing the researcher to choose the pseudonym), or remain anonymous (choosing their own pseudonym).

Who is ~~organising~~ and funding the research?

The U.S. Department of Education has funded the doctoral tuition fees for the researcher.

Who has reviewed the study?

The University of Portsmouth, Faculty of Humanities and Social Sciences Ethics Committee

What will happen to the results of the study?

The results of this study will be included in my thesis, in presentations or conferences, and in publications (such as a journal article).

What happens if something goes wrong?

You may withdraw at any time and follow the complaint procedure.

Further information and contact details.

Contact information for Allison Roberts (researcher):

Email: Allison.roberts@port.ac.uk

Telephone number: 0759 7422908 (personal) or 023 9284 6269 (department secretary)

Address: School of Social, Historical and Literary Studies

Milldam, Burnaby Road, Portsmouth, PO1 3AS

Contact information for Dr Kevin McSorley (researcher's supervisor):

Telephone number: 023 9284 2212

Address: School of Social, Historical and Literary Studies


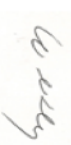
Milldam, Burnaby Road, Portsmouth, PO1 3AS

Further information can be found on the University's website:

<http://www.port.ac.uk/research/ethics/>

Thank you for reading this information sheet and for considering taking part in this research.

Appendix D: University Risk Assessment Form

 UNIVERSITY RISK ASSESSMENT FORM Version 1.0		Calculate: Probability multiplied by Severity for No/Post control scores. NB: For scores of 12 (High), or more contact the Health & Safety Office for further advice. Due to the seriousness of the 'Permanent Disability / Sight Loss and Fatal / Fatalities' factors this has been given a medium rating on the 'Unlikely' probability.				
Site/Department: School of Social, Historical and Literary Studies		Severity → HIGH MEDIUM LOW				
Task/Activity/Area: The particular activities we are assessing are the postgraduate researcher (Allison Roberts) interviewing participants for PhD, particularly in their homes if they have mobility issues. This is not the planned "standard" interview location but rather the exception (e.g., the researcher will attempt to interview in public or semi-public places). We are also assessing participant risk and transportation risk.		Highly Unlikely 1 Unlikely 2 Possible 3 Probable 4 Certain 5		Minor Injury 1 Lost time/ Ill Health 2 Major / >7 days 3 Perm. Disability/ Sight Loss 4 Fatality/ Multiple fatality 5		
Notes: (Including details of previous accidents/incidents) Risk Assessment Team: L. Allison Roberts, postgraduate researcher Dr Laura Hyman (People completing the risk assessment, minimum of 2 people)				Risk assessment start date: March 2016		
Highly unlikely: Slight chance of an accident happening	Unlikely: An unusual combination of factors would be required for an accident to happen	Possible: Not certain to happen but multiple additional unforeseen factors may result in an accident happening	Probable: Not certain to happen but one additional unforeseen factor may result in an accident happening	Certain: A high probability of an accident happening		
Minor injury: Injury requiring basic first aid i.e. Plaster or cold compress or GP	Lost time / Ill health: Injury that requires medical treatment at hospital or GP	Moderate/ > 7 days off work: An injury or work related illness reportable under The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013	Perm Disability / Eye Sight loss: Likely permanent disability Acute/ Chronic health effects	Fatality / Multiple fatality: An injury/ Ill health that results in a fatality or fatalities		
Dept. Manager (Print Name):	Dr Kevin McSorley		Signature:			
Review Date:			Reviewed by:			
Reason for review: The reason for this assessment is for the university ethics application. (Form to be reviewed annually.)						

Ref No or Task-stop	Identified hazards or Injury causes, highlighting risks (Injury focused - see checklist)	People at risk i.e. Staff, students, visitors, contractors or the public	Score -No controls (Probability x Severity = calculation)	Controls/Procedures/Key Behaviours (Existing controls, information, training etc.)	Score - Post Controls (Calculation)	Further action required	Action Priority (H/M/L)
Example: <i>Washing up</i>	<i>Risk of scalding hands from hot water. Risk of dermatitis from contact with washing-up liquid</i>	<i>Staff</i> <i>Staff</i>	<i>4 x 2 = 8 M</i> <i>3 x 2 = 6 M</i>	<i>Local protocol, put cold water in cold first and then add hot water. Mixer tap has been ordered. Latex free gloves provided. Use milder washing up liquid. Purchase long handled brush.</i>	<i>2 x 2 = 4 L</i> <i>2 x 2 = 4 L</i>	<i>Book Estates to fit new tap</i>	<i>L</i> <i>L</i>
In-home interviews	Risk of harm (verbal or physical harm)	Postgraduate student researcher	2 x 3 = 6 M	Third party (e.g., the supervisor) aware of interview place, time, and duration. Student will call when interview is completed and leave location if, at any time, feels unsafe.	2 x 2 = 4 L		L
Interviews	Psychological distress	Participant	3 x 2 = 6 M	Participant will be in control of the interview and can stop at any time if feeling drowsy. This can be in the form of a short break or stopping the interview altogether. They will be made aware of these options before the interview as well as if the researcher sees they might need a break (e.g., the researcher will offer to take a break from the questions if the participant seems stressed).	2 x 2 = 4 L		L
Travel to interview sites	Accidents on public transportation (busses, taxis, and/or trains)	Postgraduate student researcher	1 x 5 = 5 L	Ensuring the safety of public transportation falls outside the purview of this risk assessment.	1 x 5 = 5 L		L

Appendix E: 'F Med 23'

PULHHEEMS ADMINISTRATIVE PAMPHLET 2010

APPENDIX 1

Guidance for Medical Officers

COMPLETION OF FMed 23

1. The FMed 23 is the form for summarising the findings of a medical board and recording decisions made. When other documents in the electronic health care record are referred to they should be referenced, facilitating their location if required. If loose leafed sheets are incorporated, personal details (minimum service number, rank and name) and the date of the board must be included on each sheet.
2. This guidance on the completion of the FMed 23 is provided in order to ensure all relevant information is included, consistency is achieved and that the information is presented in the most suitable form. Additional guidance on the completion of FMed 23 for candidates discharged from training is at para 5.

Procedure

3. For convenience, the front sheet of the FMed 23 (see pages App 1-6 & 1-7) has been annotated with numbers referred to in the notes below. The relevant boxes on the FMed 23 should be completed in line with the guidance notes below.

Guidance Notes Relating to Annotated FMed 23 Front Sheet

1. **Full Service Number.** Self explanatory.
2. **Rank/Rating.** Use the approved abbreviations.
3. **Branch/Trade.** Use the approved abbreviations (eg RLC/Dvr, RAMC/Cbt Med Tech etc). Branch and Trade names are subject to change, and the correct terminology should be checked with the patient at the time of the Board during the initial interview.
4. **Total Full Time Service.** This information should be taken from the documentation provided by the parent medical centre for prelims. It should be checked with the patient during the initial interview. It is not necessary to corroborate this with the personnel record as a matter of routine.
5. **Surname and Forename(s).** Current full names, as they appear on the medical record, should be used. Do not include previous surnames (eg maiden names) and nick names, which should be explained in the narrative if required.
6. **Dates.** To avoid any possible confusion with dates, the correct Service date format should be used throughout. This is in the form of numbers for the day, a 3-letter abbreviation for the month, and 2 numbers for the year, such as 27 May 62.

PULHHEEMS ADMINISTRATIVE PAMPHLET 2010

7. **Command.** This is the cap badge of the individual not his/her current unit. This should be entered using recognised service abbreviations (JSP 101 refers).
8. **Ship/Unit/Station.** The current parent unit is to be listed. Note that some referrals will have come from a different unit, which has medical parenting responsibilities, and that patients may have been assigned between referral and the time of the board. This information should be checked with the patient at the time of the Board.
9. **Type of Enlistment / Commission.** Use the approved abbreviations, eg for officers, Reg C, IRC, SSC, etc, and for other ranks, NOTENG, OPEN, VENG etc.
10. **Authority of Board.** This is shown in the relevant Appendices and for Phases 1 and 2 Training may be SO1 Occ Med HQ ARTD, for APHCS may be Dir APHCS, for BFGHS – Dir BFGHS, MOD(A) Board – DGAMS. For other Boards it may be the local Senior Administrative Medical Officer.
11. **Principal Condition(s) Affecting the Medical Employment Standard Leading to Medical Board.** This section should be completed with care, as it may have a direct impact of the later award of a War Pension, an Armed Forces Pension or compensation under the AFCS. This should normally only list one condition. In exceptional cases where more than one condition has an equal effect on the award of P grades / PES, more than one condition may be listed. The justification for this should be included in the text.
12. **Place of Board.** This will normally be listed as the Medical Centre or Standing Medical Board.
13. **Date of Board and Signatures.** All dates for the Board and date of signing are to be the same, and are to be the date on which the patient was seen and the PES awarded. Delays due to typing are to be ignored.
14. **Other Condition(s) Affecting the Medical Employment Standard at the Time of the Medical Board.** Details of other medical conditions affecting the patient and contributing to the PES awarded should be listed here.
15. **Date (of Principal and other Conditions).** The date listed should be as accurate as possible, to the day. If the exact date of onset is uncertain, such as when a patient presents late with a problem, then the date of presentation should be stated with the fact noted (eg 01 Feb 08 (presented)), and the matter noted in the narrative. (eg “on 01 Feb 08, LCpl Bloggs presented with a history of wheeze of several months duration”). A separate date should be noted for each condition listed, using the same numbering system.
16. **Place of Origin.** The Place of Origin should be confined to a broad geographical area, (eg UK, Germany, SBA Cyprus, or USA etc.). If the event occurred on operations, then the inclusion of the operation is recommended (eg Op TELIC, Iraq). A separate place should be noted for each condition listed in the Principal Disabilities box, using the same numbering system.

PULHHEEMS ADMINISTRATIVE PAMPHLET 2010

17. **Ceased Duty On.** For those patients not currently at work, being TNE or on sick leave (SL), the day after the individual was last fit for duty in any capacity should be recorded. This information should be sought from the patient during the Board.

18. **PULHHEEMS and JMES.** The PULHHEEMS and JMES blocks should be completed in accordance with JSP 346.

a. **Place, Type and Date of Next Medical Board.** If the medical board wishes to review a PES at a set interval, the appropriate information should be entered here.

b. **Probable Period of Unfitness.** Those awarded a JMES other than L5 E5 are deemed to be fit. For those graded L5 E5 temp the probable period of time before return to duty / next medical board should be noted. If a period of SL is granted, then the appropriate period should be noted here.

c. For those graded MLD and above, any employment restrictions should be recorded here.

19. **Normal Date of Termination.** The current exit date should be entered here, as related to the type of enlistment/commission (see note 9). If a patient is due to leave on PVR or some other mode of exit other than at the end of their normal engagement, this should be annotated here (eg 1 May 08 (PVR)), and full details noted in the narrative.

20. **Narrative.** The following information¹ **must** be recorded.

a. Relevant medical history including medical treatment and medication (both past and planned).

b. Relevant medical examination details and findings.

c. The board is satisfied that advice about prognosis has been obtained from a relevant clinician.

d. That the board is satisfied that on-going treatment is appropriate.

e. Current Employment (including any adaptations made for medical condition).

f. Rehabilitation.

g. Social and Employment History.

h. Other considerations (eg relevant information from Appendix 18 if used, patient's wishes, Unit view etc).

i. Recommendation.

¹ Including from DMRC as appropriate.

PULHHEEMS ADMINISTRATIVE PAMPHLET 2010

- j. Confirmation that the patient was given an opportunity to ask questions and will be given a copy of the FMed 23.
- k. That the patient had the purpose and process of the Board explained, that the opportunity for questions was given, and that they gave their consent to be examined. It should also be recorded whether they gave their consent for the FMed 23 to be sent to DASA.

21. **President's Signature.** This space is for the President's signature and GMC and NMC numbers.

22. **Board Member(s) Details.** These boxes should contain the rank, initials and surnames of the Board President and Member(s) as well as their GMC and NMC numbers.

23. **Member(s) Signature(s).** These spaces are for the Member(s) signature(s).

Additional Information Relating to Army Candidates During Training

5. **FMed 23.** A contemporaneous version of FMed 23 is to be used and if loose-leafed sheets are incorporated, personal details (minimum name and service number) are to be included on each sheet. The completion of a FMed 23 for every medical discharge recommendation is mandatory. The FMed 23 must contain sufficient information to justify the recommendation made, i.e. contain sufficient details of history, examination, investigation results and specialist opinion, allowing the Confirming Officer to be able to determine a recommendation for discharge (without reference to the contents of the Medical Record)². TMMB Presidents are to ensure that the FMed 23 is completed fully and accurately. The following minimum information is to be included on the FMed 23:

- a. Date and place of pre-service medical examination.
- b. Date of and place of IME.
- c. Diagnosis and history including date of onset (and week of training of initial presentation). Include details of back-squadding if appropriate.
- d. If the medical condition existed pre-service, provide details of the following:
 - (1) Was the condition declared/undisclosed?
 - (2) The source of information, e.g. RG8 Part 1/GP records.
 - (3) Was the trainee encouraged to withhold declaration and by whom (if applicable)?

² Although there may be supporting evidence within the Medical Record, this does not necessarily stay with the medical discharge documents as they are further processed.

PULHHEEMS ADMINISTRATIVE PAMPHLET 2010

- e. Summary of examination, investigation, treatment (including rehabilitation and specialist opinion).
- f. The board is satisfied that the treatment has been appropriate.
- g. Personal aspirations of trainee.
- h. Re-enlistment criteria to be satisfied.³
- i. Recommendations given to individual.
- j. Confirmation that the individual has been given an opportunity to ask questions and has been given a copy of the FMed 23.
- k. Medical board initiated by (Medical Officer's name).

³ See Table 5/6.

No of enclosure
in F Med 4

F Med 23
Revised 04/10

RESTRICTED - MEDICAL (when completed)

MEDICAL BOARD RECORD

Service No	Rank/Rating	Branch/Trade	Date of entry
See note 1	See note 2	See note 3	See note 4. Yrs Mths
Surname	See note 5	Command / Cap Badge	See note 7
Forename(s)	See note 5	Ship/Unit/Station	See note 8
Date of Birth	See note 6	Engagement / Commission	See note 9
Date and Place of Board	See notes 6, 12 and 13	Normal Date of Termination of Full Time Service	See note 19
Authority for Board	See note 10	Ceased Duty On	See note 17
Principal condition(s) affecting the medical employment standard leading to the Medical Board		Other condition(s) affecting the medical employment standard at the time of the Medical Board	
See note 11		See note 14	
Date(s) of origin	Place(s) of origin	Date(s) of origin	Place(s) of origin
See notes 6 & 15	See note 16	See notes 6 & 15	See Note 16

FINDINGS OF THE BOARD

P	U	L	H	H	E	E	M	S	Medical Limitations* including any specific restrictions on employability and future plans (See note 18)		
Period of validity of JMES											
Date awarded		Date of review		Perm / Temp		MDS		JMES			
								A	L	M	E

* Codes: 800 – Refer to App 9; 801 – Unfit APWT; 802 – Unfit PFA; 803 – Unfit BCFT

AC 13371

App 1 - 6
RESTRICTED - MEDICAL (when completed)

Version 3

No of enclosure
in F Med 4

F Med 23
Revised 04/10

RESTRICTED - MEDICAL (when completed)

Service Number	Rank / Rating	Surname	Date of Board

Narrative (continued on FMed 15 as necessary)

See Note 20

The individual has been advised on the distribution of this information and has given consent.

	Name (with GMC / NMC No.)	Rank	Signature
President	See note 22		See note 21 (OMMB)
Member	See note 22		See note 23 (2MMB)
Member	See note 22		See note 23 (FMB)

Approval (used for MOD(A) Board)

Discharge approved under QR para [insert para]	Name	
	Rank	
Signature of MO	Appointment	
	Date	

AC 13371

App 1 - 7

Original

RESTRICTED - MEDICAL (when completed)

From:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/436803/PAP_10.pdf

Appendix F: Hasler Endeavour Centre and lodgings

(All photos taken by author on 7 July 2017.)



Above and below: Endeavour Centre entrance hall

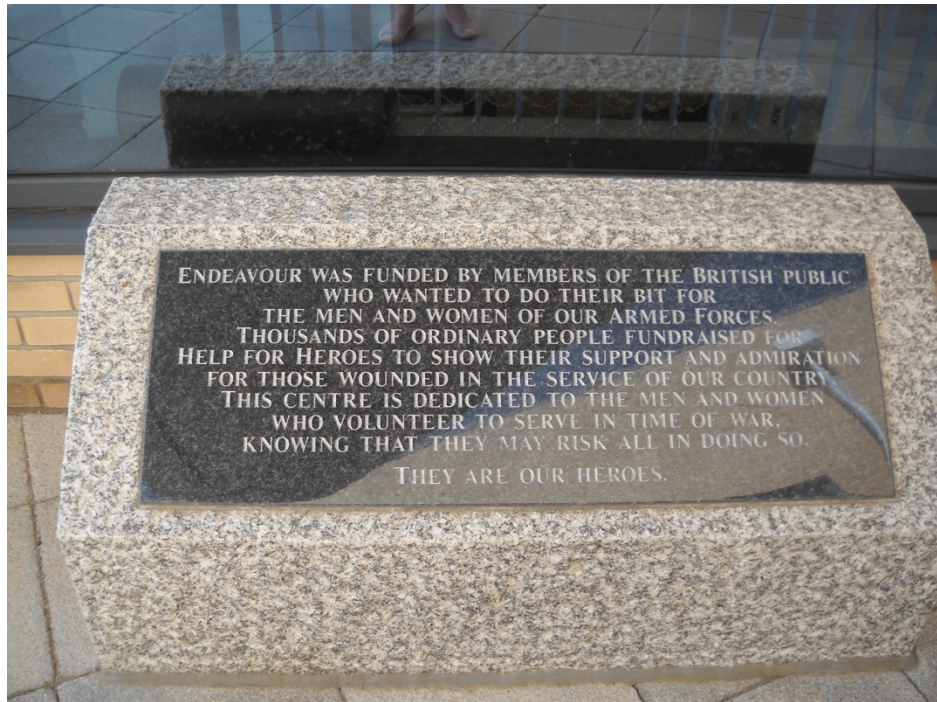




Gymnasium with climbing wall



Swimming pool in Endeavour Centre



Signage at the Endeavour Centre Entrance



Exterior of the Hasler lodgings



Above and below: Hasler lodging lounge





Rooftop lounge of the Hasler lodgings

Appendix G: University Ethics Committee Approval



24th March 2016

Dear Allison,

Study Title:	Life after Traumatic Injury: A Qualitative study of the Embodiment and Identity of UK ex Service Personnel
Ethics Committee reference:	15/16:24

Thank you for submitting your documents for ethical review. The Ethics Committee was content to grant a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the following minor conditions:

PIS

- Please amend the PIS to show the correct Ethics Committee: *University of Portsmouth, Faculty of Humanities and Social Sciences Ethics Committee*;
- Please add detail about how a complaint might be escalated in the unlikely event of it being necessary; the normal sequence is PI (student) >supervisor>Head of Department> University Complaints Officer – Samantha.hill@port.ac.uk;
- Please include an indication of the likely duration of an interview;
- It is further **recommended** that you make the point (probably a date), after which it will no longer be possible for a participant to withdraw data, clear

There is no need to submit any further evidence to the Ethics Committee; the favourable opinion has been granted with the assumption of compliance.

The favourable opinion of the EC does not grant permission or approval to undertake the research. Management permission or approval must be obtained from any host organisation, including University of Portsmouth, prior to the start of the study.

Documents reviewed

The documents reviewed by The Faculty of Humanities and Social Sciences Ethics Committee.

Document	Version	Date
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Ethics Application Form	1	09/03/2016
Participant Information Sheet,	1	09/03/2016
Consent Form	1	09/03/2016
Invitation Letter	1	09/03/2016
Advertisement Sheet	1	09/03/2016
Data management Sheet	1	09/03/2016
Interview Sheet	1	09/03/2016
Risk Assessment	1	09/03/2016

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements set out by the University of Portsmouth

After ethical review

Reporting and other requirements

The enclosed document acts as a reminder that research should be conducted with integrity and gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

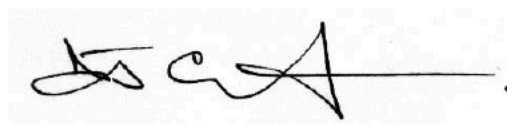
- Notifying substantial amendments
- Notification of serious breaches of the protocol
- Progress reports
- Notifying the end of the study

Feedback

You are invited to give your view of the service that you have received from the Faculty Ethics Committee. If you wish to make your views known please contact the administrator ethics-fhss@port.ac.uk

Please quote this number on all correspondence – 15/16: 25

Yours sincerely and wishing you every success in your research

A handwritten signature in black ink, appearing to be 'JCA', followed by a horizontal line.

Appendix H: Participant Consent Forms

15/16:25

Version 1.0

9 March 2016



Faculty of Humanities and Social Sciences

Mr Fergus Carr, Head of School
School of Social, Historical and Literary Studies
University of Portsmouth, Portsmouth, PO1 3AS, UK
T: +44 (0)23 9284 6036
E: sshls@port.ac.uk

CONSENT FORM, Version 1.0

Title of Project: **Life after Traumatic Injury: A Qualitative study of the Embodiment and Identity of UK ex-Service Personnel**

Name and Contact Details of Researcher(s):

Allison Roberts (researcher):
Email: Allison.roberts@port.ac.uk
Telephone number: 023 9284 6269 (department secretary)
Address: School of Social, Historical and Literary Studies
Milldam, Burnaby Road, Portsmouth, PO1 3AS

Name and Contact Details of Supervisor:

Dr Kevin McSorley (researcher's supervisor)
Email: kevin.mcsorley@port.ac.uk
Telephone number: 023 9284 2212

Please
initial or
tick box

Ethics Committee Reference Number: 15/16:25

1. I confirm that I have read and understood the information sheet dated 9 March 2016 (version 1.0) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time up to the writing of the thesis without giving any reason. ☐
3. I understand that data collected during this study, *could* be requested and looked at by regulatory authorities. I give my permission for any authority, with a legal right of access, to view data, which might identify me. Any promises of confidentiality provided by the researcher will be respected. ☐

4. I understand that the results of this study may be published and / or presented at meetings or academic conferences. I give my permission for my anonymous data, which does not identify me, to be disseminated in this way, unless I have requested to be identified. ☐
5. I agree to the data I contribute being retained for any future research that has been approved by a Research Ethics Committee. ☐
6. Anonymity is optional for this research. (If I change my mind, I am to contact the researcher to indicate my preference prior to her publication in 2018.) **Please select one from the following 4 options:**
- a. I agree to be fully identified ☐
- b. I agree to be partially identified ☐
- c. I wish to remain anonymous and will allow the researcher to choose my pseudonym ☐
- d. I wish to remain anonymous and desire to chose my own pseudonym ☐
7. I consent for my interview to be audio recorded. The recording will be transcribed and analysed for the purposes of the research. Recordings and transcripts will be stored in password-protected computers and any and documents stored will be encrypted. ☐
8. I consent to verbatim quotes being used in publications. Unless otherwise requested to use a pseudonym for me, I will not be named but I understand that there is a risk that I could be identified. ☐
9. I understand that whatever I say in the interview is confidential unless I tell the researcher that I or someone else is in immediate danger of serious harm, or the researcher sees or is told about something that is likely to cause serious harm. If that happens, the researcher will raise this with me during the interview and tell me about what could happen if I continue to talk about it and explore how I would prefer to deal ☐

with the situation. The researcher will encourage me to seek support from the NHS's Veterans Outreach Service to help me make the situation safer. If the researcher feels unsure that I will go and get support, they will talk to me about what they need to do and what might happen next. In an extreme case where a child, partner, or carer is at serious risk, and I choose not to seek help/advice the researcher has a duty to disclose this to the relevant agencies.¹

10. I would like to receive further information about the results of the study and have been informed that the main findings will be available on the researcher's website, <https://lifeafterinjurysite.wordpress.com>.

☐

11. I agree to take part in the above study.

☐

Name of Participant:

Date:

Signature:

____/____/____

Name of Person taking Consent:

Date:

Signature:

____/____/____

Note: When completed, one copy to be given to the participant, one copy to be retained in the study file

¹ Adapted from <http://www.socresonline.org.uk/19/1/2.html>

Appendix I: University Form UPR16

FORM UPR16

Research Ethics Review Checklist

Please include this completed form as an appendix to your thesis (see the Research Degrees Operational Handbook for more information)



Postgraduate Research Student (PGRS) Information		Student ID:	UP794341
PGRS Name:	Lesley Allison (Boas) Roberts		
Department:	EDSOC	First Supervisor:	Kevin McSorley
Start Date: (or progression date for Prof Doc students)	01-Oct-2015		
Study Mode and Route:	Part-time <input type="checkbox"/> Full-time <input checked="" type="checkbox"/>	MPhil <input type="checkbox"/> PhD <input checked="" type="checkbox"/>	MD <input type="checkbox"/> Professional Doctorate <input type="checkbox"/>

Title of Thesis:	Life after Traumatic Injury: Narratives of Embodiment and Identity of United Kingdom ex-Service Personnel
Thesis Word Count: (excluding ancillary data)	77576

If you are unsure about any of the following, please contact the local representative on your Faculty Ethics Committee for advice. Please note that it is your responsibility to follow the University's Ethics Policy and any relevant University, academic or professional guidelines in the conduct of your study

Although the Ethics Committee may have given your study a favourable opinion, the final responsibility for the ethical conduct of this work lies with the researcher(s).

UKRIO Finished Research Checklist:

(If you would like to know more about the checklist, please see your Faculty or Departmental Ethics Committee rep or see the online version of the full checklist at: <http://www.ukrio.org/what-we-do/code-of-practice-for-research/>)

a) Have all of your research and findings been reported accurately, honestly and within a reasonable time frame?	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
b) Have all contributions to knowledge been acknowledged?	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
c) Have you complied with all agreements relating to intellectual property, publication and authorship?	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
d) Has your research data been retained in a secure and accessible form and will it remain so for the required duration?	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
e) Does your research comply with all legal, ethical, and contractual requirements?	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

Candidate Statement:

I have considered the ethical dimensions of the above named research project, and have successfully obtained the necessary ethical approval(s)

Ethical review number(s) from Faculty Ethics Committee (or from NRES/SCREC):

15/16:25

If you have *not* submitted your work for ethical review, and/or you have answered 'No' to one or more of questions a) to e), please explain below why this is so:

Signed (PGRS):	<i>L Allison Roberts</i>	Date: 31 Dec 2019
-----------------------	--------------------------	--------------------------

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